the MODERN HOSPITAL

VOLUME 57 SEPTEMBER 1941 NUMBER 3

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CONTENTS

For September 1941

Just in Passing—

HOSPITAL strikes, priorities, nursing problems and many other hard questions facing hospitals in the next few months are due for full consideration at Atlantic City this month. If you study the programs beginning on page 65, we are sure to see you on the Boardwalk during the week beginning September 13. Whether you go or stay at home, however, you will find the comprehensive report on the convention in our October issue a welcome summary of the many meetings and events that you could not attend.

SO MANY new ideas in hospital nurseries are being brought forward these days that it is difficult for administrators to keep up with them all. That is where hospital magazines can serve. Next month we shall present another carefully planned new nursery, this one at the Luther Hospital, Eau Claire, Wis.

IN JULY, Alta M. LaBelle, housekeeper at Michael Reese Hospital, Chicago, told us what she expects from her administrator. Next month one of her former chiefs, Albert H. Scheidt, will tell us what he expects from his housekeeper. The two articles make a perfect pair.

READ AND PASS ALONG

	See page	Date
Administrator		
Purch. Agent	.....	.....
Supt. of Nurses	.....	.....
Surg. Supervisor	.....	.....
Dietitian	.....	.....
Housekeeper	.....	.....
Pharmacist	.....	.....
Engineer	.....	.....
Laundry Manager	.....	.....
Radiologist	.....	.....
Pathologist	.....	.....
Chief of Staff	.....	.....
.....	.....	.....
.....	.....	.....

Return to .....

The Modern Hospital

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"W'y, wunst, one time, when we wuz there,
We et out on the porch!" —RILEY

YOUNGSTERS used to do pretty well on simple foods like mush and milk. Before we got so fancy in our tastes coarse "vittals" were just as acceptable as the highly refined foods we now eat—and some of them still had their vitamins in them.

No physician will believe all people now suffer from vitamin deficiency, but these conditions are apparently common enough to be encountered quite frequently by most doctors. When avitaminosis seems to be a part of the clinical state, it's good medicine to bolster the dietary intake of vitamins with Gelseals 'Multicebrin' (Pan-Vitamins, Lilly). A daily prophylactic dose of *all* the better known water-soluble and fat-soluble vitamin fractions is contained in one gelseal.

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"Bored Wife to Board Member"

• Here is something new in annual reports, a little portfolio of letters reproduced in the original handwriting from Beth to her friend Molly telling the story of how she became interested in the St. Louis Society for Crippled Children and, finally, became a member of the board. In the course of her correspondence, she describes in entertaining style the story of the society and its work. The blue folder carries the title, also handwritten, "From Bored Wife to Board Member."

Let's read the first one.

> Dear Molly:
>
> Do you remember how I dreaded moving to St. Louis last year—how sure I was I'd feel lost and useless living among so many people?
>
> Well, I don't feel that way now. My neighbor took me to a meeting of the St. Louis Society for Crippled Children the other day. I've found a place where I can be of real help in St. Louis.
>
> But before I decide for sure I'm going on a tour to see everything the society does so I'll know what it's really about.

Beth proceeds to write her friend what she sees and ends by making her decision. "I've decided to accept the society's invitation to join. Now I've been let in on the inmost secrets—the books. I feel like a veteran board member. I'm proud as punch to think I have a part in it all and I can't believe that it was only a few months ago that Beth, the Bored Wife, started on her way to being Beth, the Board Member. I know 1941 is going to be even better."

Who says there is nothing new?

Evanston Stages a Show

• Three stellar attractions in one show cannot help but draw a crowd! The three day exhibit staged recently at Evanston Hospital, Evanston, Ill., proved no exception. The new $125,000 Abbott Memorial Laboratory, the presence of Dr. Roger W. DeBusk, the new medical director, and a scientific exhibit comprising 23 booths, with motion pictures and charts, brought some 3000 visitors to the hospital, the great majority of them laymen interested in learning the latest developments in the treatment of disease.

What better evidence that hospitals are becoming teaching centers? As a public relations producer, too, it is significant. Your Roving Reporter jotted down one or two suggestions for others who might be interested in entering the show business—hospital show business, that is.

Give them motion pictures, for example, and you'll have the crowd with you. At Evanston more than 75 people crammed into a room that accommodates 50 to see each reel of medical film. These depicted the fight against cancer, heart disease, whooping cough and other maladies.

Give them something dramatic to look at, something about which they may have read in the papers or heard discussed, a respirator or iron lung, perhaps, and watch them respond. They are equally interested in learning about the modern treatment of pneumonia, what's new in anesthesia and the miracles being performed in bone surgery.

To be successful, such a show must be planned carefully in advance. It must have the necessary attractions. Overcrowding may inconvenience the public a bit but it assures a better performance. Better not be too optimistic, therefore, in estimating space requirements. If it's difficult for people to get in, they'll remember and come early next time.

The latter part of the week is better than the first part. Try anyway to dismiss Monday and Tuesday from your calculations. People have more time and get more into the spirit of outside diversion as the week progresses. Evening hours, too, are best for many.

These are just a few of the facts demonstrated effectively at Evanston.

Popular With All

• No "skitterishness" about the chair which may be observed in daily use in the infirmary ward of the Worcester State Hospital, Worcester, Mass. It was designed by Laura B. Cyr of the hospital's nursing service to make things happier for elderly psychotic patients, as well as easier for those attending them; it was constructed with the aid of the hospital mechanic, according to Miss Cyr's own specifications.

The first improvisation was a low, wicker chair to which were attached two discarded wheel chair wheels and a laundry truck wheel. A broom handle was used for steering. While this device facilitated the moving of patients, it was not substantial enough for constant use. So a discarded Windsor chair, with the back removed, was substituted, marking the second stage in the development of the "Cyr" chair.

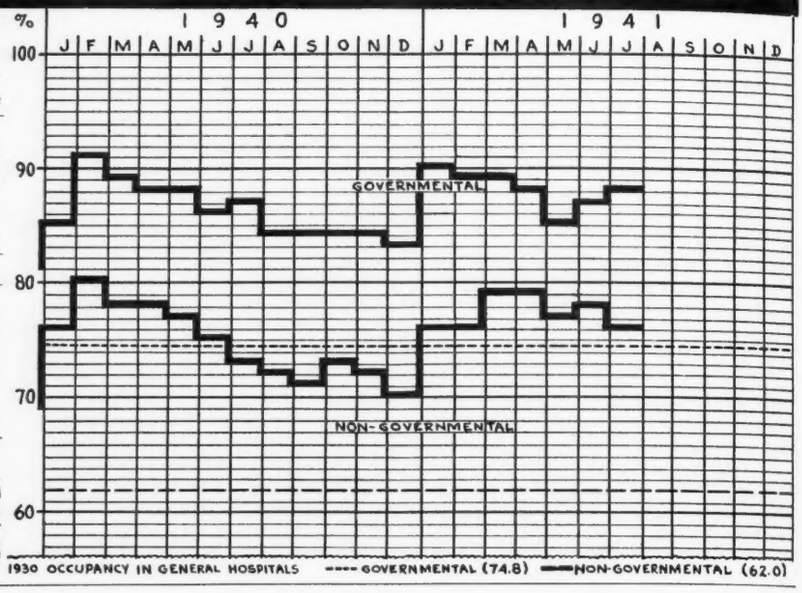
In its present improved state it is steady and will not tip even though the patient's weight is entirely on the foot rest. Its low back facilitates lifting. Its height is approximately that of the average chair and the low beds used on this type of ward. It is easily cleaned and pushed, and by placing his foot to the floor, the patient can stop the chair from wheeling. Also, the swiveled wheels permit turning it in a small space It is simply made, too, the frame being three fourths inch iron pipe welded with a small amount of three eighths inch pipe.

The chair illustrated at left was designed by Laura Cyr for elderly psychotic patients and was constructed by the mechanic at Worcester State Hospital in Worcester, Mass., where it is in daily use in the infirmary ward.

HOSPITAL OCCUPANCY BAROMETER

Type and Place	Census Data on Reporting Hospitals: Hosp.[1]	Beds[2]	1941: July	June	1940: July	June
Governmental:						
New York City	17	10,380	103*	103*	101	101
New Jersey	5	2,136	92*	92*	100	92
N. and S. Carolina	20	2,655	76*	77	74	75
New Orleans	2	2,800	83*	82	81	83
San Francisco	3	2,255	114	103	95	96
St. Paul	1	850	62*	64	67	69
Chicago	2	3,500	86*	86*	90	90
Total[4]	50	24,576	88*	87*	87	86
Nongovernmental:						
New York City[3]	70	16,526	77*	77*	72	76
New Jersey	56	8,111	79*	79*	67	75
N. & S. Carolina	109	7,913	66*	68	67	67
New Orleans	6	1,233	78*	83	84	81
San Francisco	16	3,178	80	81	73	75
St. Paul	9	1,134	70*	78	74	75
Chicago	28	5,870	74*	74*	70	72
Cleveland	15	3,085	85*	82	82	82
Total[4]	309	47,050	76	78	73	75

[1]Excluding hospitals for tuberculous and mental patients and institutional hospitals. Census data are for most recent month. [2]Excluding bassinets, usually. [3]General hospitals only. [4]Occupancy totals are unweighted averages. *Preliminary report. Complete occupancy figures for January 1933 to November 1939 are given on page 1026 of The Nineteenth Hospital Yearbook.



July Occupancy Tops Previous Years; Construction Also Heavy

Voluntary hospital occupancy in July took a slight drop over the June figures, according to preliminary reports available as we go to press. The drop from 78 to 76 per cent occupancy, however, still leaves the July occupancy well ahead of July figures for previous years. Last year the July occupancy was 73 per cent; in 1939 it was 71 per cent; in 1938 it was 69 per cent, and in 1935 it was only 61 per cent.

This slight drop in occupancy is undoubtedly a welcome relief to many of the reporting hospitals whose facilities have been severely taxed all spring.

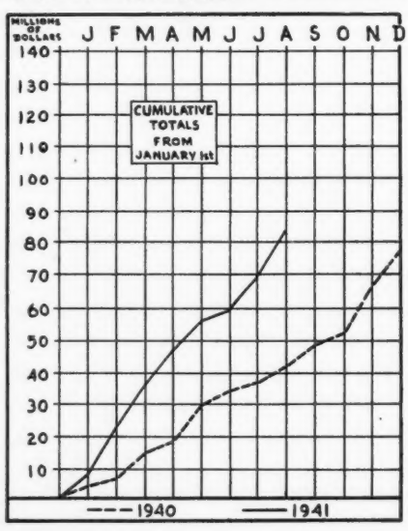
Contrary to the experience of the nongovernmental hospitals, the governmental general institutions reported an increase in July over the high figure reported in June. The percentage of occupancy rose from 87 to 88 per cent in the preliminary figures.

A large volume of new hospital construction was reported in the four weeks from July 14 to August 11. There were 62 projects of which 57 reported costs totaling $13,078,676. This brought the total estimated cost of hospital construction projects since the first of January up to $82,650,000 as compared with $41,200,000 for the same period of last year. In fact, the total from the first of the year to August 11 exceeds the total for the full twelve months of last year, which was $75,730,000. In only one year in the last seven was the total for the first eight months equal to the total recorded this year.

Commodity Price Comparisons

Commodity	July 12	August 16
General Wholesale Prices	92.7	93.5
Grain	77.5	81.5
Food	87.4	87.8
Textiles	93.0	94.9
Fuel	96.0	96.1
Building Materials	112.7	114.5
Drugs, Fine Chemicals	212.5	221.8

HOSPITAL CONSTRUCTION



Additional hospital construction may be expected as a result of the application of the Lanham, or "Community Facilities," Bill discussed in our news pages this month.

Of the 62 projects reported during the current four week period, 13 were for new hospitals of which 12 gave costs totaling $7,240,500. There are 43 additions to existing hospitals of which 39 gave costs of $5,466,128. Three alterations are to cost $115,731 and three nurses' homes will require $256,333. Of the new hospitals and extensions, several are for the United States Army and Navy, but not all by any means are in this category. There are university hospital additions and many increases scheduled for voluntary hospitals.

Price indexes of the *New York Journal of Commerce* showed sharp advances especially for grain prices.

The price index for drugs and fine chemicals of the *Oil, Paint and Drug Reporter* shot up from 212.5 on July 14 to 221.8 on August 18. This is the largest advance that this index has made in one month since it was first reported in these columns in 1934. A year ago on August 19, the index stood at 204.3.

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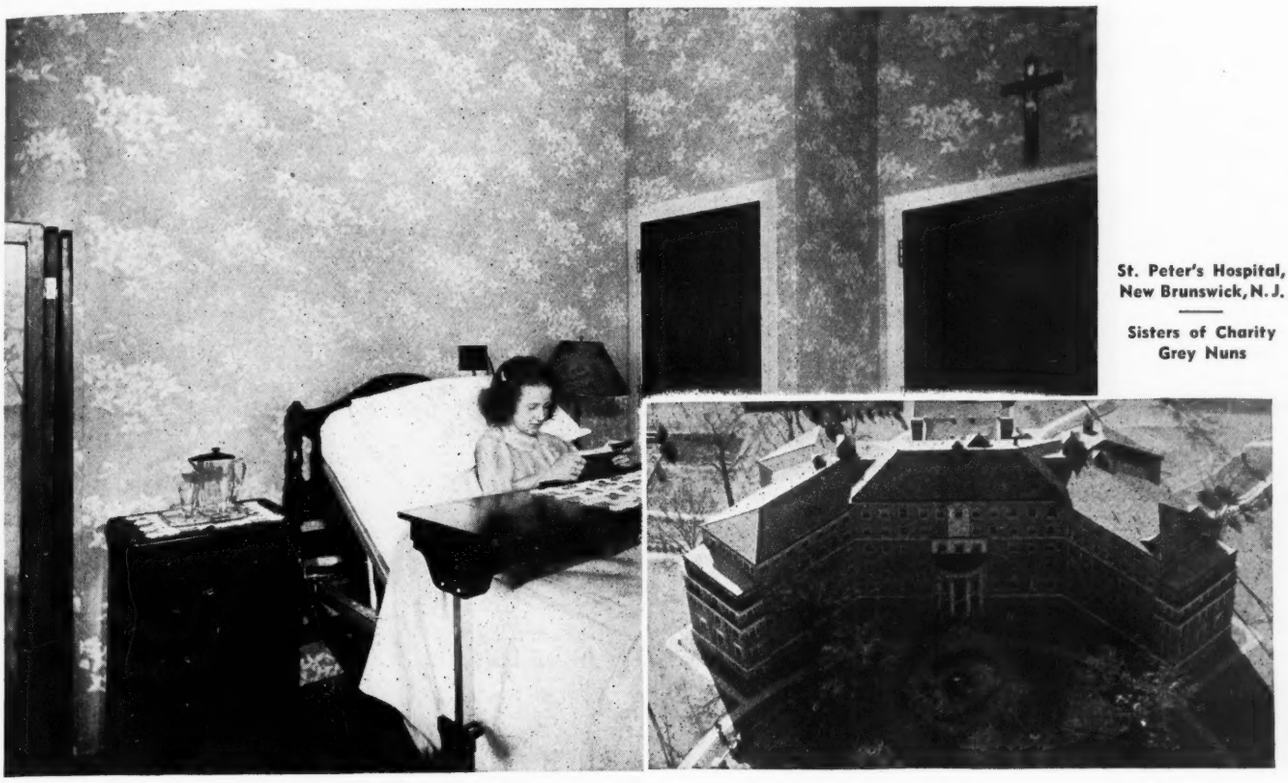

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SMALL HOSPITAL QUESTIONS

Conducted by Gladys Brandt, R.N., Children's Free Hospital, Louisville, Ky., Alloys F. Branton, M. D., Willmar Hospital, Willmar, Minn.; Jewell W. Thrasher, R.N., Frasier-Ellis Hospital, Dothan, Ala.; William J. Donnelly, Princeton Hospital, Princeton, N. J., and others

Office Personnel

Question: Who is responsible for patients' accounts and collections and how many office employes are needed in a 60 bed hospital?—L.E.J., Va.

ANSWER: In the office of a 60 bed hospital, business hours of which are from 7 a.m. to 7 p.m., personnel schedules might be as follows:

Day Clerks: 7 a.m. to 3:30 p.m., 9 a.m. to 5:30 p.m. and 3:30 p.m. to midnight.

Night Clerk: 11:30 p.m. to 8 a.m., or 12 midnight to 8:30 a.m.

Bookkeeper: 8:30 a.m. to 5 p.m.

Day Receptionist: 10 a.m. to 7 p.m., or 12 noon to 8:30 p.m.

One half hour should be allowed for meals.

The clerks' duties include switchboard, admissions, mail, messages and assistance to the superintendent and bookkeeper. Each has definite duties. Each knows the bookkeeping system and can post and balance the day's earnings and income, write receipts and establish balance on accounts. They can relieve one another during absences. The bookkeeper knows the clerks' routine duties.

The number of personnel can be reduced and added to depending on the activity of the hospital, service demands and extensiveness of detailed accounting of expenditures and inventories, as well as office space. There should be no less than four clerks, presuming there is the essential medical record librarian on the staff.

The bookkeeper's time is devoted to accounts of patients and includes collecting accounts, establishing immediate arrangement for payment, consulting with the superintendent regarding questionable accounts, rendering weekly statements, "following promises," mailing monthly statements, suggesting accounts for collector and agencies. The superintendent interviews "delinquents." The bookkeeper will require daily assistance from one of the clerks.

In some instances, the night superintendent can cover many clerical duties, perhaps eliminating the night clerk service.—GLADYS BRANDT.

Pharmaceutical Cost Control

Question: In a small hospital with no pharmacy, how can the number and cost of pharmaceuticals be controlled?—R.C., N. J.

ANSWER: The cost can be controlled in two ways: by buying direct in the name of the hospital or by buying in as large quantities as possible.

The number of pharmaceuticals purchased can be controlled, first, by making a survey of the number of drugs used and the number of calls for each drug. With this survey in hand, approach the staff with a proposition of limiting the number with the idea that it should be necessary to stock only those drugs that are continuously used as shown by past experience. The personal appeal to the doctors usually helps the situation.—A. F. BRANTON, M.D.

Interns and Case Histories

Question: How do you stimulate interns and residents to do good history taking? Can it be done?—A.G.W., T.H.

ANSWER: Yes, it can be done. The following is an outline of what I believe to be a simple, workable plan.

1. When the new residents and interns arrive, have the intern committee and the hospital administrator meet with the group and explain just what type of histories the hospital expects to receive from them.

2. The intern must be treated as a doctor by both the hospital administration and the staff. He should be allowed as free rein with patients as is practicable in private practice. He should be allowed as much surgery as can be done without endangering the patient, *i.e.* closing the incision after abdominal operations and being allowed "first assists" as often as possible.

3. The hospital should provide itself with an ample number of interns, selected carefully and all of about the same scholastic standing.

4. The intern should be given comfortable quarters, good meals and ample time off. Interns, like other human beings, become tired and overworked. A disgruntled intern does not take good histories nor does he do anything else as well as he could and should. Interns should be given to understand that the amount of time off will depend on the completion of their histories and the quality of them.

5. Stimulation should come from the medical staff. The attending physician should read the history, make corrections or additions and sign it as a mark of approval. Some doctors write a commendatory note on a particularly good history. Doctors should give the intern an opportunity to discuss cases with them. In a word, if the staff men are good teachers with a real interest in their interns, results will be amazing in their success.

6. Interns take better histories when they know these histories may be used at pathological conferences or staff meetings. Histories so used should be praised or censured as they deserve at these meetings.

7. The hospital should provide a medical stenographer or dictaphone to assist the doctor, intern or resident whenever he has an unusual number of new admissions on his service.—SISTER M. PATRICIA, O.S.B.

Accounting

Question: Should a 75 bed hospital prepare its monthly financial reports on a cash or on an accrual basis?—J.D., Ill.

ANSWER: A statement prepared on an accrual basis is more accurate and informative. A cash report does not show accurately the operations of the hospital. Cash receipts in June, for example, may represent largely payments for services rendered in May and prior months. On the other hand, cash disbursements in June may represent purchases made in May for supplies to be consumed over a period of months. The accrual basis will reflect the income and expenses for the particular month. Further, the cash receipts basis furnishes a real problem in determining departmental income which the accrual basis automatically eliminates. —ROBERT PENN, C.P.A.

Infants' Records

Question: In obstetrical cases is the baby given a separate hospital number and, if so, how is the newborn infant's record filed in the permanent files?—M.A., Mich.

ANSWER: In many cases a newborn baby is given a separate hospital number. The chart with this number on it is then filed in its own folder. The alphabetically arranged card index file is cross-indexed and the number of the baby's chart is placed on the mother's card in the permanent files.

In other cases the mother's number is given to the baby with the letter "A" added and the baby's record is filed with the mother's as a single history. Since all statistics do not include the newborn in the census, if the baby is admitted under its mother's number and its history incorporated with the mother's and filed under that number, the scrial number will then agree with the total number of admissions shown on the hospital's records on any given date.—EDNA H. NELSON.

LOOKING FORWARD

Problems at Atlantic City

BECAUSE war is each week coming closer to our shores, the forthcoming convention of the American Hospital Association may be the most important one in its history. Vital decisions must be made. They must be based on clear, straight thinking.

While there are multitudinous problems, five of them stand out with particular importance. These deal with defense, personnel, hospital service plans, finance and maintenance of standards.

In the field of defense, hospital people will be anxious to receive reports on the many activities carried on since the Boston meeting. The joint committee of the three national hospital associations, the council on governmental relations of the A.H.A. and the subcommittee on hospitals of the health and defense committee of the Federal Security Agency have all been active. The problems of the actual defense of our coastal areas has been occupying Mayor La Guardia's Office of Civilian Defense. The health section of this office will have important suggestions regarding water and power supplies, sewage disposal, evacuation of patients and similar matters.

The impending shortage of various types of hospital supplies and equipment may become serious, although this problem has been studied by government officials and trade groups and appears to be well on the way to solution. It will continue to be necessary, however, for hospitals to economize as much as possible and, probably, to accept substitutes for certain desired products. If prices of supplies are not kept within reasonable limits, the finances of hospitals may be seriously threatened.

Regarding hospital personnel, the present situation is mixed. Interns and residents are now apparently protected until they complete their necessary educational experience. This is an important improvement over the situation a year ago. Whether this arrangement will supply enough doctors to the armed forces is, however, still an unanswered question. The shortage of nurses threatens to become more acute. This is being met by increases in student enrollment, reemployment of nurses in retirement and wider use of nurse aids and volunteers. Federal funds have already been made available to aid in this program. Closer collaboration and deeper understanding between the nursing and hospital groups are urgently needed. Steps in this direction have recently been taken through joint meetings of the A.H.A. and the nursing groups.

Serious shortages of x-ray and laboratory technicians, dietitians, occupational therapists, physical therapists, nurse anesthetists and other technical personnel must be faced.

The problem of the nonprofessional hospital workers is becoming more acute not only by virtue of competition from industry but also because of increased unionization in this field. Efforts to obtain old age retirement provisions for this group should be pushed steadily. Even this, and the higher wages that will necessarily be paid, may not be sufficient to bring stability to this working force. A sound personnel relations program should be developed for hospitals.

The program for bringing the hospital service plans into the A.H.A. as type IV members has now been developed so that it overcomes all legitimate objections. The house of delegates should give it an overwhelming vote of approval. But this is only the beginning of the problem. Every encouragement must be speedily given to the growth of true ward service plans for those of low income. Hospitals that follow the real philosophy of voluntaryism will cooperate in this endeavor, even if it means taking such patients at less than actual cost. Dr. S. S. Goldwater recently stated the philosophy of such plans so ably that it needs no repetition. Unless low cost plans are developed promptly and on a sound basis, there is reason to think that certain powerful officials in Washington will press vigorously for the adoption of a compulsory health insurance plan under the guise of disability insurance required by the emergency.

A public relations program, financed and directed jointly by the plans and the A.H.A., is to be presented also at Atlantic City. This is long overdue and should be given favorable attention.

The increasingly difficult financial position of hospitals, of course, will receive consideration. Some recommendations for meeting this situation certainly should be proposed. Increased rates, increased governmental payments to hospitals, especially for expenses incident to the present emergency, and increased voluntary support are all important possibilities.

Finally, careful consideration should be given to the problem of hospital standards. What standards, representing luxury service or nonessentials, can be discarded readily for the emergency? What standards

are basic to good hospital care and should not be lowered until no alternative is possible? Sound advice on this subject from the leaders in the hospital field would be welcome in many institutions.

Interpreting "Emergencies"

NOT the least of the problems attending the present international situation that hospital administrators must face this fall and winter is the diversion of public interest from hospital service to defense and relief service. Attracted by the dramatization of war duties, lay groups comprising board members and members of women's auxiliaries are being tempted to assume new and more exciting obligations farther afield, at a sacrifice of the more prosaic daily tasks that plead attention on their very doorsteps.

There is every indication that board meetings, already poorly attended in too many instances, will find even fewer places occupied, because of pressing problems elsewhere. Already the great contribution that women are making to hospital work is threatened by the inroads of war volunteer service. One woman put it recently: "I can't hope to give as much time as formerly because of this present emergency."

But what is more vital to this "present emergency" than our hospitals? Now, if ever, administrators have need of the best brains and abilities in the community to help solve their ever increasing problems. What institution is more directly identified with "emergencies" than the hospital? What is of greater importance to nations at war than adequate facilities with which to care for the injured and to maintain the health of the civilian population?

Internship, 1941

WHAT is happening in the rest of the world must naturally affect internships as well as other professional positions in hospitals. Medical schools have been improved in quality but they have been reduced in number. Requirements for admission, graduation, practice and specialty certification have been raised continuously. These developments have kept pace with the multiplication of hospital beds with a consequent reduction in the supply of house officers to the danger point. The defense program has now entered to aggravate the problem.

That the supply of interns does not meet a reasonable demand in this country has been known to us for several years. We shall have to leave this problem to the educators, with any help that the field of hospital administration can give, but the immediate problem of the management of the sick in hospitals is ours.

The field of hospital administration, looking as far into the future as it can, should undertake a careful analysis of house staff duties at a time like this. The time of the intern must be conserved for medical services that no substitute can perform. Clinical time should be balanced against clerical time and the training of medical aids in a variety of services should be developed so as to leave the intern free for the professional care of his patients.

We now have the highly specialized nurse, the social worker, the occupational therapy aid, the physical therapy technician and the laboratory technician at our disposal in limited numbers. The need for such workers was foreseen in a much earlier day. The American Conference on Hospital Service in 1922 resolved, among other things: "To outline a plan for the education and training of nonmedical clinical aids in history taking, clinical recording, first-aid surgical dressings, technic of the operating room, laboratory technic and other service incidental to diagnosis and treatment."

It is clear that several things must happen before the present situation will become more favorable. Facilities for the training of nonmedical aids to serve in hospitals without interns or in hospitals with a limited house staff will have to be organized. Meantime, recent graduates of the hospital and junior members of the visiting staff will have to come in and help out in emergencies. The closed hospital will have to relax its rules in the presence of competent physicians whose practice lies outside its walls. Financial subsidies will have to be provided for young physicians performing house staff duties on a full-time or part-time basis. Whenever possible house officers will have to be retained after graduation, receiving payment in money after reasonable payment in education has been made.

Merited Recognition

THE improvement in the quality of Negro hospitals in the United States in the past decade has been steady and significant. A generous part of the credit for this improvement certainly can be given to administrators of these hospitals and to their organization, the National Hospital Association.

Recently, as reported in our news columns this month, public recognition has been made of the outstanding abilities of two administrators of Negro hospitals. A. W. Dent, administrator of the Flint-Goodridge Hospital of New Orleans, has been appointed president of Dillard University with which the hospital is affiliated. Dr. John W. Lawlah, medical director of Provident Hospital, Chicago, has been appointed dean of the medical school of Howard University, Washington, D. C. These signal honors cannot but encourage other Negro administrators.

Further evidence of the desire of Negro administrators to prepare themselves fully for their responsibilities and of the cooperation extended them in this respect is the admission of a Negro this fall to the course in hospital administration of the University of Chicago. Negro administrators have been attending the hospital institutes assiduously and in increasing numbers for several years.

The Psychiatric Hospital—
An Aid in Medical Preparedness

RONALD H. KETTLE, M.D., and EMERICK FRIEDMAN, M.D.

Assistant Superintendent and Senior Physician, Respectively Norwich State Hospital, Norwich, Conn.

PSYCHIATRIC problems that arose in the course of our previous military era imposed a severe economic burden on the citizens of this country. The end of this is not yet in sight. Emotional and other psychiatric illnesses occurred not only among combatant men but also among enlisted men who were not even near a zone of active military or naval operations. Many of these cases had their onset long after hostilities ended.

The present system of warfare as learned from formal or unofficial communications seems to involve civilians as much as, or even more than, military forces in both physical and emotional upheavals. This would lead to the assumption that the incidence of psychiatric disorders that arose from the World War will be considerably increased in this era if a comprehensive scheme of prevention is not included in our system of modern psychiatry.

Psychiatric Phase Overlooked

As far as can be ascertained, there has been no clear-cut formulation of standard practice for handling the psychiatric phases of military medical practice during the present period of preparations. The psychiatric resources of the nation have been included in our present defense measures only in general and passive terms. These resources have not been systematized or organized so that they can perform their maximum function in the event of a national emergency.

The state psychiatric hospitals, combining community attachments, medical connections, governmental affiliations, legal possibilities and research intentions, are in a unique position to handle emergency psychiatric problems. The majority of physicians engaged in neuropsychiatric work are associated with state hospitals if not actually on resident staffs. Yet the state psychiatric hospital, in spite of these facts, has been relegated to the background in both general medical and neuropsychiatric defense preparations.

If a state hospital organization were analyzed for basic divisions for utilization in a national military emergency, the units as given in the accompanying table would be at once apparent. The listing is given in order of temporal sequences.

Basic Divisions of a State Hospital Into Units of Military Utilization

For Direct Neuropsychiatric Utilization:
1. Social Service
2. Psychology
3. Medical, Nursing
4. Recording, Statistical
5. Laboratory

For Accessory Utilization:
6. Nutritional
7. Industrial, Occupational Therapy

The social service unit would play its rôle in the gathering and presentation of historical, anamnestic data concerning the hereditary, economic, social and personality factors of draftees. This information may be obtained readily and the procedure would necessitate only moderate elaboration of present-day state hospital social service activities. If the case of a draftee is referred (all draftees should eventually be referred), the social service department would investigate, as they do with their routine cases, the following sources.

1. The case records of an average state hospital that has been in existence for about twenty years. These records would list from 10,000 to 20,000 cases, most of whom came from the hospital's own district. These records have been classified alphabetically and according to type of illness in most hospitals. They would provide an important source of information concerning not only the draftee but also his family, antecedents, descendants and siblings. Some of these, in turn, may also be draftees, so that psychiatric or emotional findings may be listed for quite an imposing number of people, particularly if employes are similarly classified.

2. Correctional and penal institutions together with their probationary or parole departments. Proportionate numbers of case records that describe the maladjustments and socio-economic statuses of a large group of people, inmates, parolees and their relatives, would be found here.

3. Records from schools in the community. The years of intellectual progress in numerous cases would be outlined in these records. Difficulties in assimilation of school knowledge, behavior problems, unusual habits and, in many instances, special aptitudes or ineptitudes are described in great detail. Vocational and technical school rosters should give extremely important data for future placement of draftees.

Economic Histories Available

4. Exchange agencies, which have been organized in all urban and many rural communities. In these agencies are records, going back for many years, of all persons and families who have applied for aid. These records are usually quite detailed and contain, chiefly, information about the economic histories of these people. Personality problems, indicative of psychopathic features in certain cases, have been clearly pointed out in records obtained from these agencies. Previous institutionalizations in state hospitals or prisons are also described.

5. Welfare and occupational agencies, many of which are closely associated with exchange agencies and governmental offices. Here may be found more elaborate, more detailed

personal records, similar to those previously mentioned but drawn from smaller community groups. These records give information about financial, domestic and psychiatric events in groups of families and individuals over a period of years. Occupational placement histories with special aptitudes, experiences or difficulties at work are readily available.

6. Interviews with relatives and families of given cases by the social service department of a state hospital with or without investigation of the actual domestic setup. From this source important direct data regarding the characteristics of the individual, his interpersonal relationship in the total domestic and marital background may be gathered.

These sources of information should be coordinated for easy access and evaluation. Centralization for these sources in the state hospital and proportionate increase in the personnel of the agencies mentioned are the chief practical problems. The past history of the draftee or prospective military candidate may then be obtained rapidly; pertinent psychiatric, neurologic, emotional features may then be listed together with special personality and experiential trends.

Inasmuch as special exemption regulations already have been made for cases of organic, nervous and mental diseases, pronounced mental deficiency, functional psychoses, criminality and allied conditions, the rapid accumulation of positive information of these facts would hasten necessary exclusion of the psychiatrically and neurologically unfit without more work by physicians and military boards.

Those cases, however, that have a history of minor psychiatric or emotional disturbances, that have displayed social or domestic maladjustments, that are known or suspected of psychopathic personality traits or lesser intellectual inferiority would likewise be presented for psychiatric evaluation. It would seem possible to have all such information at hand at the time draftees and military candidates are being considered for induction. Special aptitudes and experience would also be indicated for future evaluation.

Cases of draftees and military candidates who have been listed as questionable by the foregoing methods would then be turned over to the staff of the psychology unit. Of special importance would be the already obtained educational and vocational histories. Psychological testing would proceed in accordance with data presented. From previous experience it is known that batteries of tests can be administered to groups of candidates so that little increase in personnel would be necessary to make this an actively participating unit in this organization. Special aptitude tests, coordination tests under special conditions and placement recommendations would be included in the functioning of this unit.

To facilitate active participation of this state hospital unit in the military medical organization of the nation, the obviously important recommendation to be made is that not only should a neuropsychiatrist be placed on every draft board but the state hospital staff should be represented in an important position on the several boards that lie in its district.

Active participation of the state hospital staff does not mean that staff members must be present at the place of induction. Regular hours for interviewing and examining military candidates and, when indicated, the military or naval men already inducted could be set aside. It would seem more judicious to keep state hospital staffs intact and have military men come to the latter for examination and proper evaluation than to take psychiatrists from the hospital to various military or naval centers.

From the practical standpoint, no unusual enlargement of state hospital staffs would be required. The organization procedure of staffs for this purpose would need, chiefly, a schedule of longer hours to include both routine hospital work and military work. The cost of this projected organization would be much less than the present one which calls for the withdrawal of the state hospital physician to military bases. Technically, state hospitals are already under governmental or public jurisdiction and their inclusion in a greater military program should not be a difficult problem.

Call for Nurses Issued

THOMAS PARRAN, M.D.
Surgeon General, U. S. Public Health Service

THE Army and Navy together need 10,000 nurses to care for their personnel. To meet fully the needs for visiting nurses, public health nurses and nurses for the defense industries will require at least double that number. This means that 30,000 nurses may be drained away from their ordinary occupations in the civilian hospitals and the homes of the sick. The total of nurses in the United States does not begin to be enough to meet all eventualities. We need to double or triple, promptly, the number of women competent to do some nursing task.

Congress has just approved my recommendation for federal aid to nurses' training. This money will be used to increase the nurse power of the country on four fronts:

First, we shall begin refresher courses in various parts of the country to equip inactive nurses to return to duty, releasing younger women for military service.

Second, we shall proceed as rapidly as possible to increase the capacity of nursing schools.

Third, the Red Cross First Reserve of Nurses will mobilize for military needs the nurse power now available. This is the official register from which the Army and Navy select their nurses. Every nurse who is qualified to enroll in that reserve owes it to herself, her profession and her country to enter her name upon the register immediately. She must not postpone it, thinking that there is no emergency. For the nurses of America there is a very real emergency. Their skilled help is needed now.

The fourth front upon which it is proposed to increase our nurse power is in the training of nurses' aids. In England at war they have been able to meet their health and medical needs only by a dilution of professional services, with one trained person in charge of several less well-trained assistants who can do specific tasks competently and loyally.

Excerpt from radio address given on June 26, 1941.

Volunteer Nursing Aids

For National Emergency Service

AVIS VAN LEW, R.N.
Touro Infirmary, New Orleans

IN OUTLINING a volunteer nurse aid course there are three objectives to be kept in mind.

One is to train an intelligent group of women to give simple bedside care and to make them familiar with the routine and policies of the hospital in which they are to work.

Another is to prepare them to assist the nurses in disaster relief in case of floods, fire or bombing by giving them the essentials of first aid.

The last is to make them familiar with the problems connected with the care of the sick in the home and to teach them how to solve those problems.

The careful selection of students for the nurse aid course is of paramount importance. Only women who have an interest in the needs of the hospital and have a sense of community responsibility will prove worth the investment to the hospital. From experience it has been learned that those best fitted for this work are young matrons who are comfortably settled in their own homes. Many of them have children and know something about sickness; their judgment is more mature than younger persons and most of them have learned to work with their hands.

Such organizations as the Council of Jewish Women, the Junior League and the Diocesan Council of Catholic Women are composed of the type of persons that would make desirable candidates for the nurse aid course. These organizations are closely and carefully governed, the standard of their work is high and the members have a responsibility to the group as a whole when the task is undertaken.

When the hospital agrees to give the nurse aid course, the outline may be presented to the chairman of the organization or some other key person who is held responsible for organizing the class. Since the chairman will know the members personally, she can select the candidates, interpret the policies and in other ways save the hospital from an endless amount of trial and error.

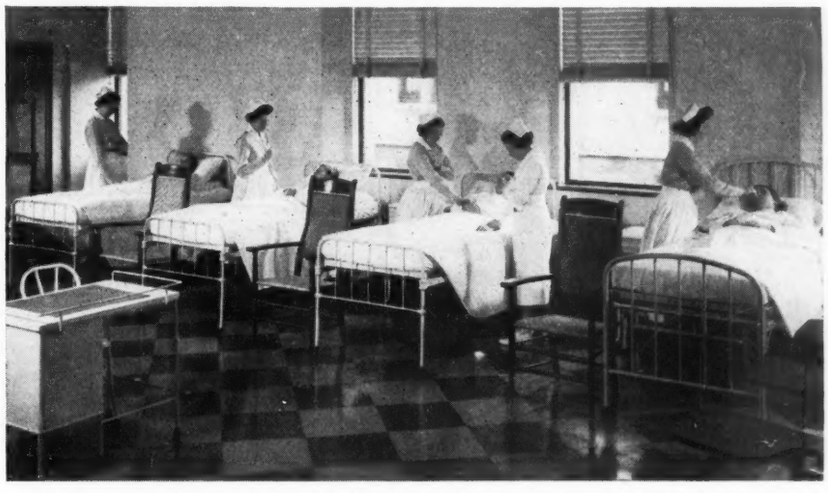
The policies of the course are made by the advisory committee, composed of representatives of the organization, the hospital and the nursing profession; thus the women's organizations share the responsibility for the success of the course with the members of the hospital staff.

The policies have to do with eligibility for membership; they regulate the length of the course, hours on duty and uniforms worn. In addition, they list the authorized duties in the hospital and make provisions for records and reports.

The course outline, as well as the policies, is made and submitted to the organization before enrollment begins, to ensure thorough understanding between the hospital and the lay group. At this time the women may well be advised of the responsibility that they must necessarily assume if they expect to help with the care of the sick.

The size of the group that can be adequately handled in the classroom and carefully supervised in the practice room should be stated at the outset. When the quota is filled, no one else should be allowed to enter. The number of students will depend upon the amount of time that the instructor can devote to the class and the available teaching facilities. It is believed that 24 students should be the maximum and that less than 16 is a waste of time.

It is essential that the instructor be a graduate nurse of good professional standing. She must be in good physical health, well groomed and attractive in appearance. She must also have a good educational and cultural background in order to command the respect and inspire the confidence of a group of well-educated women. Some college preparation for teaching and experience in ward management are almost necessities.



Under supervision, nurse aids learn to take temperatures and pulse count.

It is important that the instructor be familiar with the hospital setup where the volunteers are to work, as her personal contact with the supervisors in charge of these departments makes for smooth running during the clinical experience period.

Last, there must be enthusiasm for the undertaking, coupled with the feeling that the instructor herself is doing her share of the defense program.

The cost of the course is considered from the standpoint of both the hospital and the student. The expense to the hospital includes primarily the salaries of the instructor and the ward supervisors and the cost of the materials used in the

practice room. The expense to the student includes a nominal fee imposed to ensure regular class attendance, a textbook, uniforms and a watch with a second hand. If a chest plate is made as a part of the physical examination, the student pays the minimum price.

The course is best outlined by the instructor herself. This is no small matter when one considers lesson plans for a group whose age, intelligence, interest and previous experience are unknown. Yet the material must be factual, must be presented on a level that all can understand and each lesson must be sufficiently interesting that the students will want to continue.

To Determine Course's Length

The time devoted to the classroom and practice work will be in direct proportion to the number of duties that the nurse aids are allowed to perform. To be of real help to the nurse the list of duties will necessarily be long and, ordinarily, the course will require approximately fifty-two hours in the classroom. This should be completed, if possible, within a period of two months. In addition, it will be necessary to give the student some clinical experience in the hospital. This can be given easily in one month by asking the students to spend a four hour period twice a week on the wards. The entire work, therefore, totals eighty-eight hours in a period of three months.

After the course is completed a short refresher course each year is recommended for the aids who do not volunteer service regularly.

Any classroom that is large enough to accommodate a bed for demonstration purposes can be used for the course. The greatest difficulty is getting enough beds for practice work, since the ratio of beds to students should be one to two. If a group of 24 students is divided into two laboratory sections, there must be a minimum of six beds. The nursing arts classroom is an ideal place for the class.

Instruction is divided into general and special.

The general instruction is given by the nurse in charge of the course and consists of lectures, demonstrations, recitations and class discussions. By these methods the aids are taught the procedures that they will be allowed to perform in the hospital: caring for the patient's environment; giving baths and making empty beds; helping with trays, feeding patients and passing nourishments between meals; taking temperature, pulse and respiration; giving simple purgative enemata and carrying bedpans and urinals; assisting with admission and discharge of patients; taking patients to and from various departments; making supplies and helping with inventories; answering telephones and escorting visitors; carrying messages and running errands.

A workable plan is to give a demonstration on Monday followed that afternoon by a two hour laboratory section for half the students. The other half returns for the practice period on Tuesday morning. Another lecture is given on Wednesday, followed by a two hour laboratory section that afternoon and another period on Thursday morning. A special lecture session is held on Friday.

The special lectures are given by various heads of departments and administrators to introduce the students to these people and to give them an appreciation of their work.

At the conclusion of the classroom work, a written examination of the objective type is recommended. An average grade of 75 per cent for graduation is not too high if the standard of the course is to be kept at a high level.

The part of the course devoted to clinical experience can be much more elastic as far as the schedule is concerned than can the classroom instruction period. The only requirements are that the volunteers attend one lecture a week and that they have thirty-two hours of clinical experience in a month. They are advised to spend two four-hour periods on the wards each week. If each nurse aid has a substitute, this pair is permitted to work whenever it is most convenient for both, but the wards to which they are assigned for their particular shifts are to be covered by one or the other.

The working day is divided into three shifts of four hour periods: 7 to 11 a.m., 11 a.m. to 3 p.m. and 3 to 7 p.m. Each week the aids are asked to work one of the peak load shifts when morning and evening care is given and they may work one lighter midday shift for the other period.

If a notebook is kept in a convenient place, the nurse aids can register when they go on duty and the time spent in the hospital can be totaled easily at the end of the month.

The reaction of the nurse aids to the ward situation is no different than that of a young preliminary nurse. She is afraid of everything and everybody and feels unnecessary. If the supervisor in charge of the ward has a work assignment ready for her when she arrives, her four hour period will pass quickly and she will soon learn to organize her work so that she will be of real help.

Her happiness on the wards will depend on how she is received by the members of the hospital personnel. Graduates and students should be told beforehand that the women are volunteering their time to help the nurses so that they will be made to feel welcome.

Patients' Reaction to Aids

Patients as well as nurses need to be informed of the presence of this group. This will alleviate the embarrassment that the aid experiences when a patient asks her to please get a nurse when he wants only some small task performed. When patients are forewarned, it has been found that they are interested in new faces and variety in uniform; in most cases they have a deep appreciation for the service rendered by the aids.

Nurse aids are requested to refrain from discussing patients among themselves and with outsiders. Certain information is kept from them and they are not permitted to read charts. In a notebook provided for that purpose, the aid can easily jot down any pertinent information that she has gathered concerning patients and this information can be transferred to the chart later by a nurse.

Certificates are presented by the hospital to the aids at the completion of the course on the recommendations of the instructor and supervisors. Eligibility for graduation is based on attendance and classroom work. The ward supervisor's report concerning personal attitude toward work, reliability and adaptability is also considered.

This Credit Plan Helps

FRANK B. GAIL

Business Manager, West Jersey Homeopathic Hospital, Camden, N. J.

A bugaboo in so many hospitals, the credit problem, Mr. Gail believes, has been partially solved at New Jersey Homeopathic through a small bank loan. This is another of those articles dealing with medical economics which The MODERN HOSPITAL brings its readers with the hope that each new idea may be an incentive for organizing the individual institution into a well-rounded enterprise, just as sound commercially as it is both professionally and scientifically

SCENE: The admitting office of any hospital.

CHARACTERS: Patient or his responsible representative; admitting officer.

ADMITTING OFFICER—Mr. Jones, your bill covering your operation and all the incidental expenses for the approximate time of your hospitalization will be about $100. I have detailed it here for your information. Our rules for private accommodations require the first week's payment in advance. Your subsequent bills will be rendered weekly in advance and the final bill is to be paid before you leave the hospital.

PATIENT—I am sorry, Miss Smith, but I am afraid I can't meet those requirements. I receive a reasonable, steady income from my employment, but my family obligations have prevented me from accumulating any reserve funds for an emergency such as this. I am always willing to pay my obligations if given time, but the best I can do is to promise to pay $10 each month until the bill is paid. I do not wish to enter a ward and be a charity patient in any degree. I can pay my way if given time.

A. O.—But, Mr. Jones, that means that the hospital must wait ten months before the final installment is paid. Our obligations to our creditors must be paid each month and our receipts from private patients are never sufficient to care for the charity work we are called upon to render. Is there no other way you can help us? Have you any source from which you can borrow a sum such as you will need?

P.—Miss Smith, I should certainly like to see the hospital receive its money immediately but I have no collateral and I cannot embarrass myself and my friends by asking them to endorse my note for a bank loan. I cannot afford the high rates of loan companies and I have no insurance against which I can borrow. Does that answer your question?

A. O.—That is very complete, Mr. Jones, and certainly closes the door against those forms of borrowing. The hospital also has no desire to work any hardship on you to pay this bill; however, would you be interested in borrowing $100 if I could show you how it could be done through a local bank, without the embarrassment of asking your friends to endorse for you and without any red tape or trouble on your part? You will not even have to go to the bank to execute the note and your monthly installments over a period of one year will be less than the $10 monthly you agree you can pay the hospital. Besides, you will have the satisfaction of knowing that the hospital receives its money immediately.

P.—That sounds almost too good to be true. If I could accomplish all that I should most certainly like to handle it that way. Won't you explain to me how it can be done?

SUCH a scene occurs many times in hospitals today and the foregoing financial arrangement appears to be a welcome solution to a serious problem. We at West Jersey Homeopathic Hospital, Camden, N. J., feel that our problem has been solved.

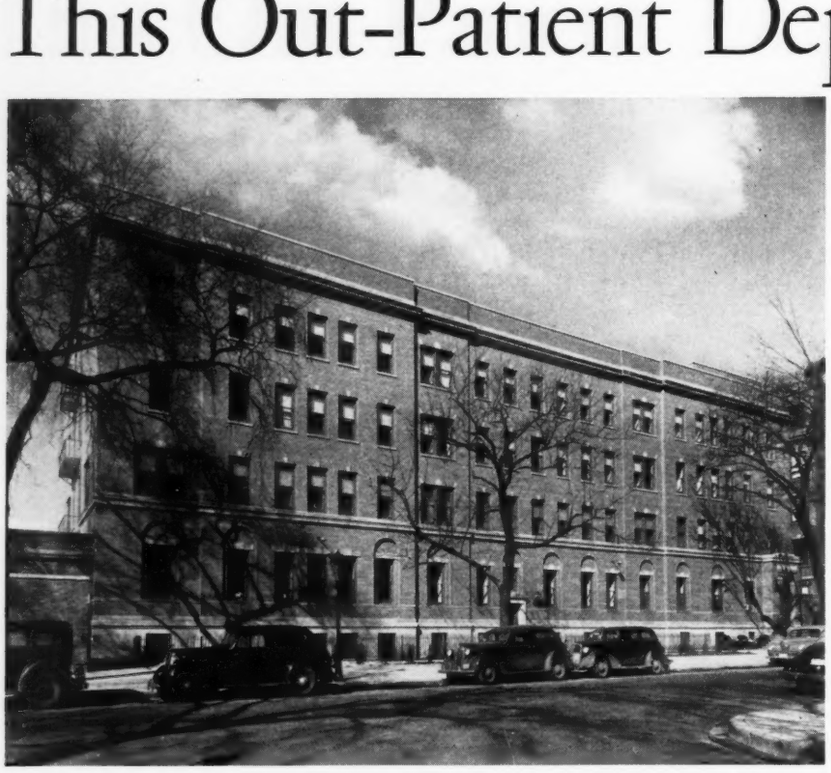
Arrangements have been made with one of our local banks, through its small loan department, by which a blanket endorsement is given the bank by the authorized officers of the hospital to cover a certain specified sum (in our state the limit is $1000); the patients borrow against this amount. Of course, this sum is being constantly reduced by the monthly payments of the borrowers and we have never yet reached our limit, but the plan is becoming so popular that we are now considering starting the same plan with one of the other banks.

The note form used is the same one the bank uses in its small loan department. Not more than six essential questions need be asked the patient, because most of the necessary information has already been obtained through the admission form. The patient does not go to the bank, all details being arranged right in the hospital office. Six per cent interest on the whole sum is added to the note when it is made.

We receive our money immediately when the bank receives the signed note and then the bank proceeds to exercise the same collection procedure in operation with its other clients who have borrowed through the regular channels. The hospital receives from the bank a monthly statement of the arrearages of each hospital borrower and this gives us the opportunity to contact the patient and possibly facilitate the payment of the installment. In case of default for sixty days, the hospital makes good the unpaid balance and we then proceed to collect from the patient through our regular methods.

Of course, reasonable precautions must be taken to extend this plan only to responsible persons and good financial risks such as the banks themselves would accommodate.

This Out-Patient Department Is



MABEL W. BINNER
Administrator
Children's Memorial Hospital, Chicago

FOR many years Children's Memorial Hospital, Chicago, had felt the need for more adequate housing for the out-patient department. This department, organized in 1902, was located in the basement of one and then another of the several hospital buildings. Additions of space had never kept up with the growth in clinic attendance, which reached 70,519 visits a year in 1933, with a daily average of 230 visits.

In 1934 a gift of $560,000 was made to the hospital by Gwethalyn Jones in memory of her uncle, Thomas D. Jones, president of the board of trustees from 1914 to 1927. In considering the use of this fund many hospital needs were reviewed. None, however, seemed so pressing as the need for better housing of the clinic.

Early in 1935 the board authorized a detailed survey of the situation. The superintendent, with the assistance of the chief of medical staff and director of the clinic, prepared a questionnaire covering the needs of the clinic. Following a careful analysis of this outline a trip was planned to clinics in seven states by these three members of the hospital administrative staff and the architect, in order that facilities could be observed and evaluated critically from the four points of view. While this method may seem unnecessarily costly, we have avoided mistakes in construction which can be so disappointing and which are all too frequent in institutional building.

On a site directly south of the administration building a five story building, 48 feet deep, 170 feet in length, with a wing at the center 40 feet by 48 feet, was erected. While definite planning began in 1935, ground was not broken until April 1939; the building was occupied in November 1940.

The clinic building comprises a total of 168 examining rooms, treatment rooms and offices arranged on five floors as follows:

Ground Floor: The doctors' auditorium, seating 72; hospital admitting unit; medical record storage room; x-ray film storage; drug storage and manufacturing room; solution manufacturing room; clerical offices; locker rooms.

First Floor: Detention unit at entrance for suspected or known communicable disease; cashier; clinic admitting unit and waiting room; pharmacy; social service department.

Second Floor: Baby clinic; orthopedic departments; medical record room; x-ray department; basal metabolism; photography.

Third Floor: General medicine; general surgery; branch laboratory.

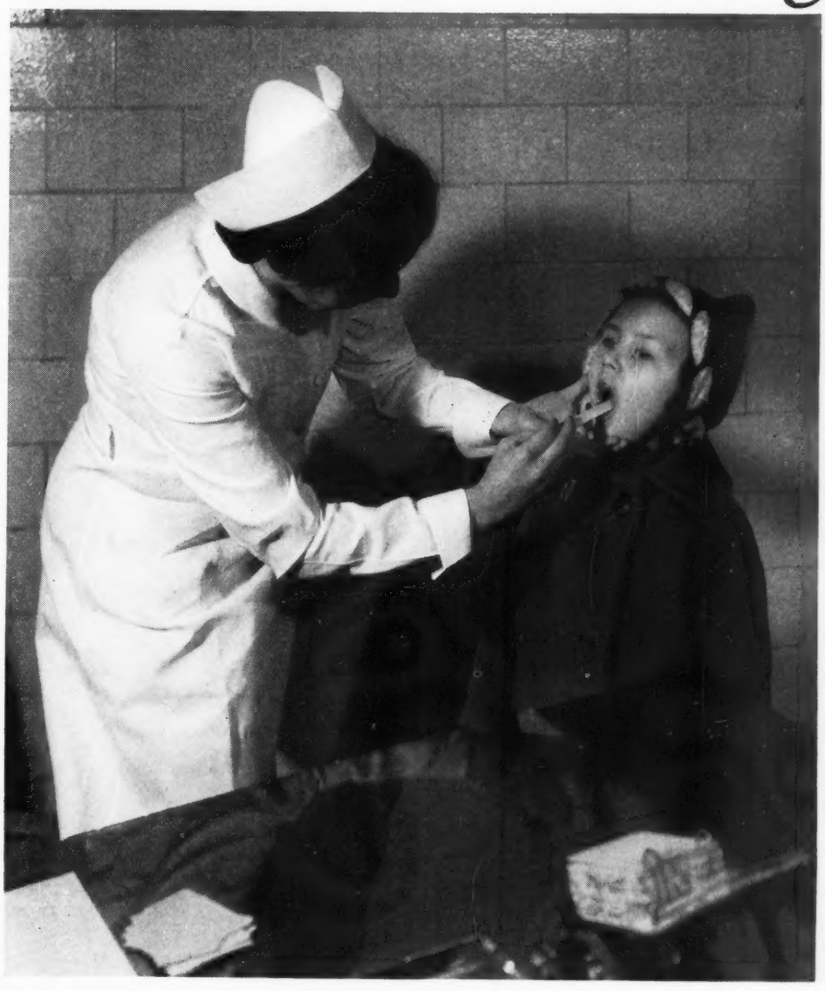
Fourth Floor: Special clinics; nose and throat; eye; dental; endoscopic unit; branch research laboratory; unassigned space in west wing, 40 feet by 48 feet.

No building receives harder wear than that housing many people and concentrating much activity in a few hours daily. In constructing such a building, therefore, materials that will reduce maintenance costs to a minimum must be used. Provision must be made for medical records and for auxiliary services, such as the

Above: Exterior of clinic building. Left: View of the bronchoscopic room. Right, Above: As patients enter the clinic, each is examined for symptoms of communicable disease. Right: One of the large waiting rooms that are provided at Children's Memorial Hospital for the convenience of patients and adults who accompany them.

Outgrowth of Careful Planning

PUCKEY & JENKINS
Architects, Chicago

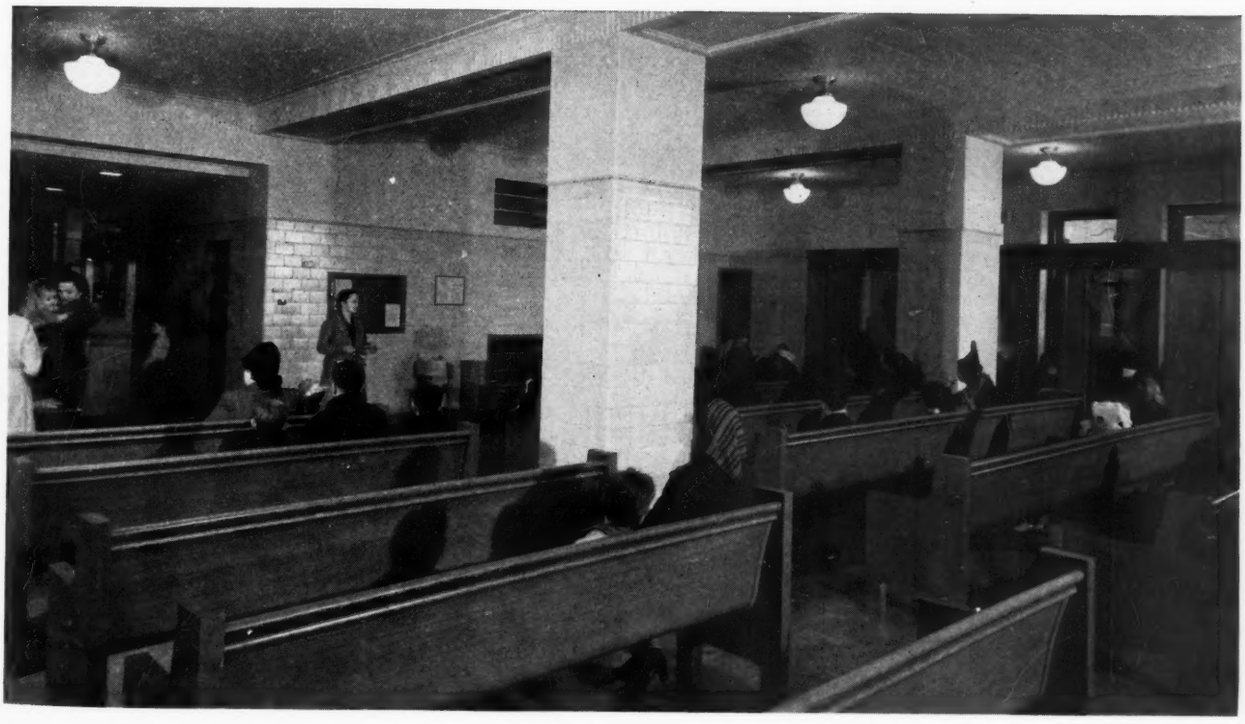


pharmacy and the social service and x-ray departments.

While acoustical treatment of all ceilings was considered desirable, it was installed only where it was considered most necessary. The ceilings are painted a light cream color. All woodwork, including benches, is in walnut finish.

A glazed cream brick with pebbled surface was used for all walls. This is almost indestructible, is easily washed and does not produce a glare. The flooring is of asphalt tile. Of three methods tried, the physicians preferred foot pedal control on all examining room lavatories. A simple device raises the pedals out of the way so that floor cleaning is easily accomplished.

It was necessary to provide adequate and decentralized waiting room space as our patients are always accompanied by at least one adult. It was necessary, also, to provide space for detection of communicable disease and segregation of the patient when this is discovered. More than the usual number of washrooms is



Above: Entrance to clinic building. Below: Plan of first floor. Arrows show how traffic is routed for safe and efficient handling of all incoming patients.

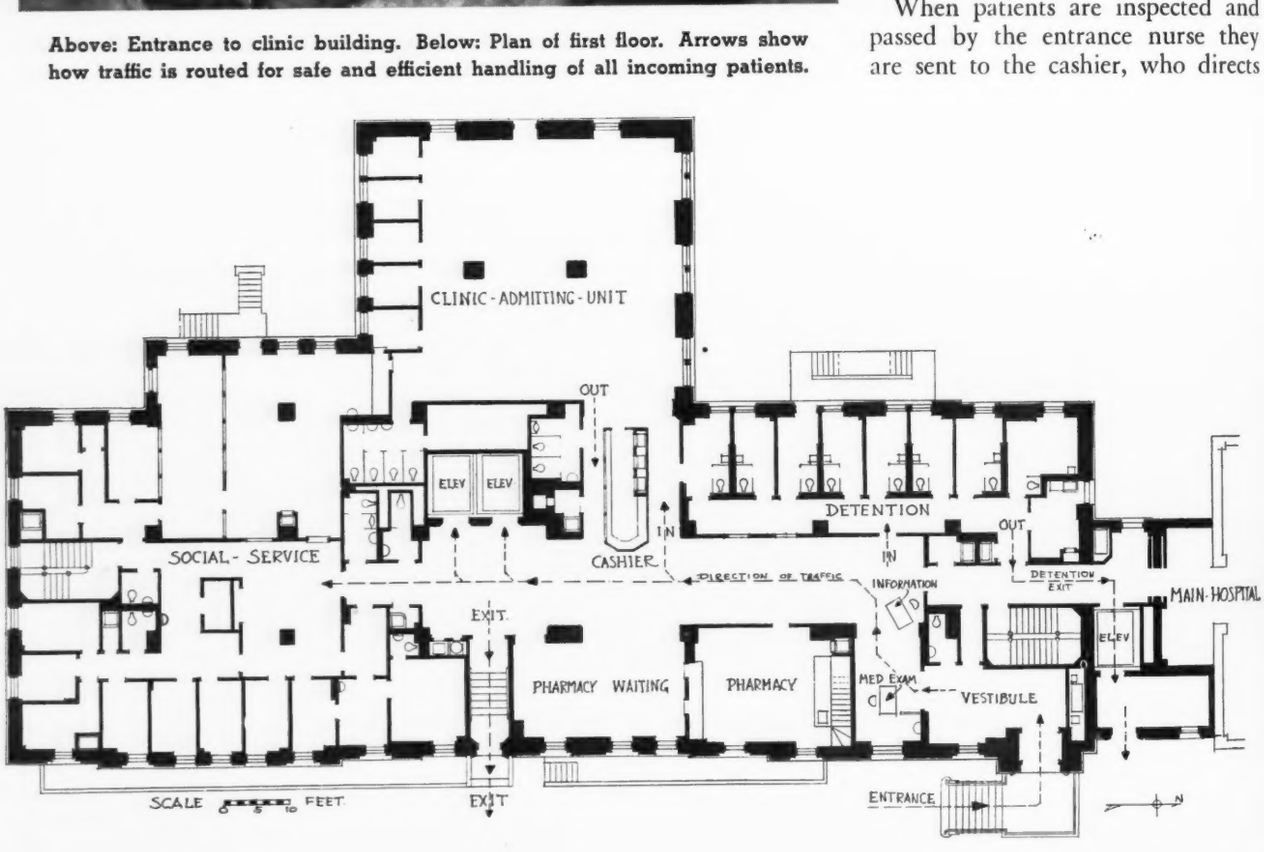
required in a children's clinic. These must be located in the immediate proximity of waiting and examining rooms.

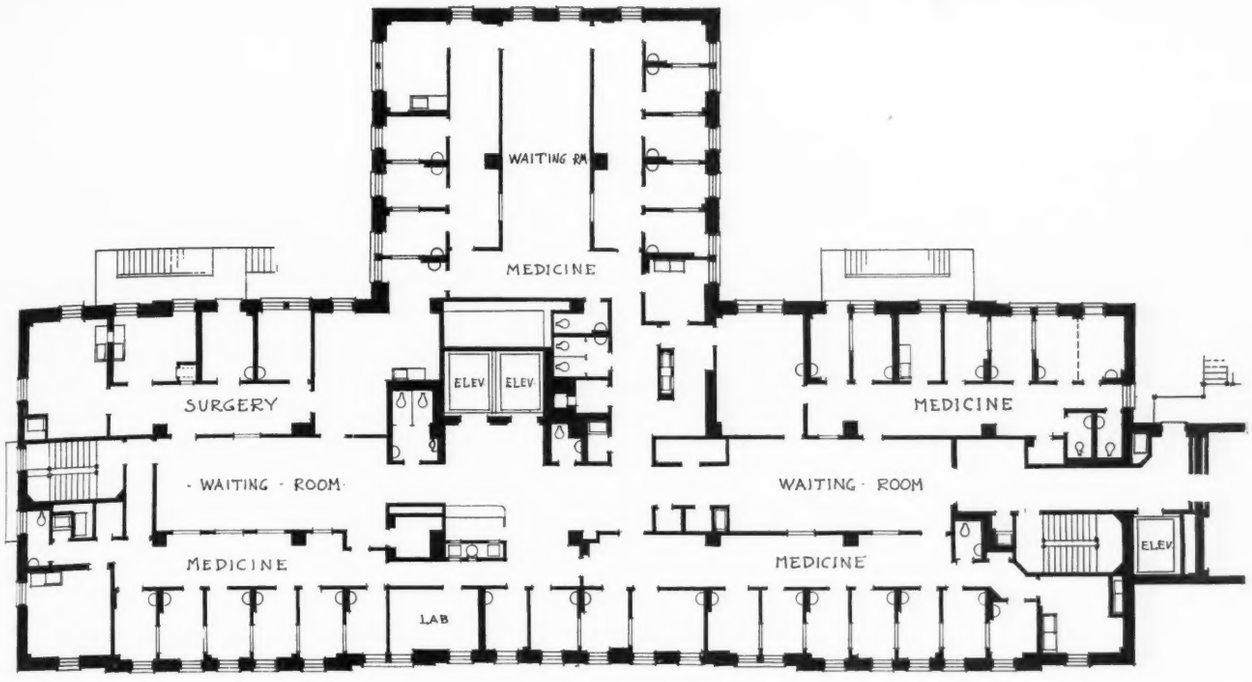
The movement of traffic in a clinic should proceed along smoothly in one direction from entrance to exit with bottlenecks and cross lines of traffic avoided. For this reason the entrance and exit in the new building were located sufficiently far apart to avoid congestion.

If the patient arrives very early in the morning, before the clinic doors are open, he enters a large vestibule, in which he is sheltered from cold or rain until the inner doors are opened. Seating facilities are not provided in this vestibule as we do not wish to encourage too early arrival, with possible congestion.

A nurse is stationed at the entrance to inspect every patient for symptoms of communicable disease. If there is any history or evidence of contagion the patient is placed in one of eight rooms in the detention unit. This unit is at the entrance. Each room has a toilet and lavatory. Following examination by a physician, if a diagnosis of communicable disease is made the patient is held until removed by the health department. A separate exit is used for removal of the patient from the building.

When patients are inspected and passed by the entrance nurse they are sent to the cashier, who directs



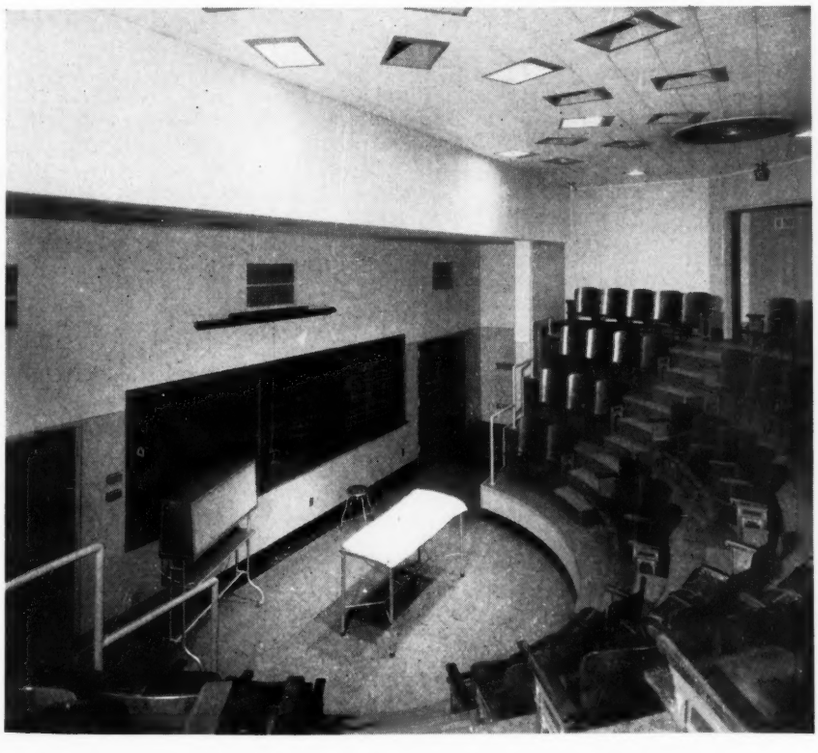


Above: Third floor plan where general medical and surgical departments are located. Below: The doctors' lecture room on the ground floor seating 72.

new patients to the waiting room for interview before proceeding further. Old patients are registered by the cashier, records are procured and the patient is directed to clinics on the second, third and fourth floors, as the case may be.

Each floor has an appointment desk directly opposite the center elevators. Patients are assigned to one of the waiting rooms in each of the wings on every floor. After the patient has been examined and following all other treatments, if a prescription is written this is brought to the pharmacy by the parent. The pharmacy is located at the exit of the building. At no time during this routing does the patient return to the entrance.

The typical examining room is 6 feet 3 inches by 9 feet. Because of the size of the room, furnishings have been reduced to a minimum. The examining table was especially designed by hospital personnel. It is of stainless metal, with a concealed drawer for clean linen and with hamper for soiled linen. This is attached to the table and swings under it when not in use. The writing table was also especially designed. It is made of steel with aluminum finish and composition top. The chair and examining stools are of aluminum.



A signal system operates from the desk in each wing to the examining room so that physicians can receive notification regarding telephone and other messages to be called for at the desk.

Adjoining each wing are utility rooms, janitors' rooms and weight and temperature units. At least one larger examining room is located in each wing in order that teaching of small groups may be carried on. Blackboards are installed in each of these rooms.

For services that are available to both clinic and hospital patients, location was of extreme importance because out-patients and in-patients should not have contact with one another. This was worked out satisfactorily by locating these departments in the north wings of the clinic building, which adjoin the hospital. There are two entrances to the doctors' lecture room, a corridor and anteroom at one side for out-patients and a corridor and anteroom at the other side for hospital patients.

"Passed by the Censor"

London, England, July 9, 1941

From S. R. SPELLER, LL.B. (Lond.)
Editor, The Hospital

DEAR Colleagues in America:

As I write, a new list of awards for civilian bravery during enemy air attacks has just been issued. Many of those to whom awards are now made earned them during the mass attack on Coventry some months ago. In the list of awards of the George Medal, I read the following:

"SIDNEY CECIL HILL, house governor and secretary, JOYCE ELIZABETH BURTON, matron, EMMA HORNE, nursing sister, Coventry and Warwickshire Hospital, Coventry.

"During an enemy air attack the hospital was heavily damaged by direct hits with bombs.

"Mr. Hill worked all night during and after the raid. He led parties to put out fires and to extricate patients from the ruined wards. After the explosion of a time bomb which wrecked part of the basement, he led a party down one of the tunnels and, at great risk, rescued a number of patients. Miss Burton went round the wards throughout the raid regardless of personal danger, cheering the patients and encouraging her nursing staff. Whenever a ward was hit she was quickly on the scene, directing and helping with the rescue work. By her courage and example she was largely responsible for the high morale of the patients and nursing staff.

"Sister Horne was on duty on the second floor when a direct hit carried away the end of a ward. She reassured the patients and spared no efforts to evacuate them to the basement. Two other wards then received direct hits and Sister Horne went to these wards and, regardless of personal danger, helped to pull patients from the wreckage and remove them to safety. Later, she managed to release a junior nurse who was trapped under debris and stayed with her in conditions of great danger until further help came."

Now, brave as are the actions that earned the award I mentioned, I quote them not as exceptions but as examples. Similar episodes have occurred during practically every air attack on this country in the course of which many hospitals have suffered severe damage. Indeed, there must be numberless acts of bravery that have passed unknown and, therefore, unrecognized. This fact has been appreciated by the board of the West Bromwich and District General Hospital, which, realizing that the whole of its nursing staff present on the night when that hospital suffered severe damage had acted with exceptional bravery and devotion to duty, and knowing that public recognition of everybody is impracticable, has inaugurated a nurses' scholarship fund out of which grants will be made toward postgraduate training of any nurse who was present on the night in question. That is an example I should like to see followed in every hospital.

As it is not my intention in my monthly news letter to waste the readers' time, as well as my own, in somewhat sentimental treatment of what are, after all, hard facts, I shall now turn from this tale of senseless and wanton destruction and of heroism among the common people to examine the effect of the damage done on the postwar hospital problem.

Even before the war some people were speculating on whether large hospitals should or should not remain in the center of the big cities. At Birmingham, the big new Queen Elizabeth Hospital, opened shortly before the war, was built some three or four miles from the center of the city close to the headquarters of the university. On the other hand, such important institutions as the Birmingham Childrens' Hospital still remain in the thickly populated industrial areas of the city.

IN MANY parts of the country in which immediate rebuilding of hospitals was not a matter of urgency before the war, consideration of the question of rebuilding farther out was not of immediate importance because, in many cases, it would have been financially unsound to abandon a perfectly good hospital for the sake of a possible balance of advantage on the side of the establishment of country hospitals, the more especially since well-informed people were not all on one side and since those hospitals that had moved from the center had not all elected to move in order to go into the country but simply to go into other centers of population that had grown up, as in the case of London, some four or five miles from the center.

That was the meaning of the action taken by King's College Hospital many years ago when its board decided that that hospital should remove to Denmark Hill in the midst of a closely packed working class population. On the other hand, when Westminster Hospital found it necessary to rebuild, two or three years ago, a site only a short distance from the old hospital was chosen and it was elected to keep practically all departments on the spot but organized on a different plan from that hitherto adopted.

The air attack, which has caused such extensive damage to so many of our large hospitals, has thus given an opportunity for a reexamination of the problem of location unhindered by considerations of finance, since in many cases there will have to be rebuilding whether in the big centers of the population or outside. I shall, therefore, give you just the briefest outline of the factors in the decision to be made that occur to me.

YEARS ago, everything was in favor of having our hospitals for in-patients in the center of our big cities. The reasons that can be suggested are:

1. **Traveling.** In any event it would have been necessary to keep a casualty and out-patient department at the center of population and it would have been difficult to maintain ambulance facilities for the patients and transport for the staff between the small hospital in the center and an in-patient department on the outskirts of the city. Moreover, our professional staff in London, all of whom would have had private specialist practices, would expect to have their hospital within easy reach of Harley Street or Wimpole Street.

The development of modern transport has weakened considerably the objections under this heading and within the Emergency Hospitals Service our hospitals have now had considerable experience of working in cooperation with in-patient departments scattered throughout the areas they serve.

2. **Convenience of Patients and Visitors.** As out-patients would still be taken care of at a branch of the hospital in the center of population even though in-patients were removed to the outskirts, the plan apparently would not be financially detrimental to the poorer patients. The new idea itself, however, involves complications as regards visitors. It would undoubtedly be a real hardship to the relatives of poor patients who had been transferred to the outer hospital to have to spend money two or three times a week on

(*Continued on page* 136)

Promoting Harmonious Relations

Among the Hospital Personnel

W. B. FORSTER

Personnel Director and Assistant to the Superintendent
St. Luke's Hospital, Cleveland

NOT long ago an employe came to the personnel officer of a hospital and asked, "How much must I take from my department head before I am justified in losing my temper?"

It was pointed out to this worker that she had done the proper thing in presenting her problem to the personnel officer rather than in losing her temper. Her problem was adjusted readily but her question exemplifies three points of attack on the problem of promoting harmonious employe relations: first, employes must be trained to get along together; second, we must provide an "escape valve" for grievances, and third, the department heads must be trained in the proper use of authority.

Many wide-awake hospitals have come to recognize the value of personnel training. Training of waitresses, housekeeping maids, telephone operators, division helpers and orderlies seems to be a fairly general practice as evidenced by articles published from time to time and by papers read at various hospital conventions. A large portion of the time spent on these training programs is devoted to the technical aspects of the job at hand, since the major objective of such training is to teach the employe how to do his job better.

Learning to Work Together

It might be well, however, to keep in mind a secondary objective of orienting and adjusting the employe to the general problem of working with others and the specific problem of all working together in an institution. The magnitude of hospital work necessitates the existence of certain people to give orders and of others to take those orders and complete the tasks; the definition and discussion of problems arising from such a relationship have proved to be a valuable addition to a training program.

Perhaps the matter of training an employe to get along with his fellow workers might better be spoken of as a courtesy propaganda drive: "courtesy," because many unpleasant relationships are purely the result of bad manners; "propaganda," because it must be a continual process of education. A salient fact about all personnel education is that it must be repeated frequently if it is to be effective.

A logical time to start emphasizing the importance of tact and courtesy is at the initial interview when the prospective employe is introduced to the job by means of the job specification. It seems significant that several hospitals which have well-organized personnel departments list in their job specifications "courtesy, tact and the ability to get along with people" in the same paragraph with the educational and experience requirements of the job.

The fact that these qualities are of such a nature that they are rather difficult for a personnel officer to detect in an interview makes it evident that they are included to impress the candidate with their importance. Furthermore, the ability to get along with one's fellow workers is not an inherited or an innate characteristic but it is a trait that can be developed quickly, once its necessity and importance are established in the mind of the worker.

The conventional training class presents an excellent opportunity to show the employe what is meant by exercising tact and courtesy in the carrying out of everyday tasks. Discussions on how an orderly should receive a complaint from a patient or a visitor or how a waitress should respond to an employe's tantrum over his lunch have proved helpful.

Unfriendly exchanges among employes often indicate a low morale owing to the worker's belief that the work is not being done efficiently. Maybe he has a genuine interest in improving service and, since no other outlet is provided, he attempts to correct the matter in his own way. The training class is a good place to explain the organization of the hospital with special emphasis on the lines of authority so that there may be no question about the employe's error in attempting to enforce his will even if it seems to him at the time to be for the good of the institution.

On the other hand, we can scarcely blame the worker for wanting to take action on something he thinks is wrong; to fail to provide an easy and sympathetic audience for his complaint is to invite unharmonious relationships, not only among the employes themselves but also between the personnel and the administration.

How to Handle Grievances

Tead and Metcalf in their book entitled "Personnel Administration"[1] say, "It (a grievance) can be treated in one of two ways. It can be ignored —in which case a sense of thwarted, suppressed and antagonistic emotion tends to develop. The original cause of the maladjustment tends to be magnified or distorted and, if other grievances occur before the first is corrected, a progressively intense, sensitive and unreasoning conviction of ill-treatment is fostered. Nothing tends to create a more unfavorable atmosphere among the employes than an accumulation of unheard, unrecognized and, therefore, uncorrected grievances.

"The second method of treatment is, therefore, the only safe one. Let in the light, air and sunshine upon all grievances! Let everyone get every critical comment or complaint off his chest at once. Keep the air clear and the atmosphere free of any vague uneasiness. This can be accomplished in only one way: have an organized channel of communication between the workers and the management through which the worker can make his grievance heard with confidence that it will be promptly and constructively considered.

"This provision will be effective to the extent that it displays fairness in

[1] Tead and Metcalf: Personnel Administration, McGraw-Hill, 1933. Pp. 225.

operation and thus retains the worker's confidence."

Under the old rule of thumb method of administration, of which we still see evidences from time to time, it was thought to be an unpardonable breach of conduct for an employe to go "over the head" of his immediate superior by taking his grievance to someone higher in the organization. Such a system tends to encourage despotism among department heads because they know that unreasonable orders may not be questioned. This does not infer that grievances should not be presented to the department head, for employes should be encouraged to take their problems there first. However, if the employe is not satisfied with the result of that conference or if the worker has any reason, no matter how trivial, for not taking the complaint to his superior in the first place, then he should be able to talk to the personnel officer or to the superintendent without prejudicing his interests in the smallest degree. Of course, the personnel officer and the superintendent will exercise caution not to undermine the authority of the department head.

In addition to an "open door" policy toward personnel grievances, it has been found helpful to have members of the personnel department move about in the organization, mingle with the workers and establish cordial relationships with them. Experience has proved repeatedly that one gathers more constructive criticism and more real grievances, which employes consider too trivial to justify a trip to the personnel office, than could possibly be obtained in any other way. Furthermore, it tends to establish the personnel officer as a natural confidant of the worker.

The misuse of authority seems to be a universal human failing. The phrase "drunk with power" is well known to all. You will recall in Act II, Scene II of *Measure for Measure,* Shakespeare wrote:

> "But man, proud man,
> Drest in a little brief authority,...
> Plays such fantastic tricks before high heaven
> As make the angels weep."

Those in possession of authority might increase their skill in its use if they bear in mind certain basic truths. No one likes to receive commands, yet the desire to excel at one's job is universal; orders can be given in such a way as to make an employe feel small and unimportant or they can be given in a way that makes him feel that he is a respected worker with an important task to do. An occasional word of praise from one's "boss" frequently causes an employe to attack with enthusiasm a job which he formerly felt to be drudgery. The phrases, "would you like to" and "don't you think we should," as a preface to orders seem to bear magic influence in reducing the stigma of subservience.

Supervisors must be reminded from time to time not to make issues of single happenings. The auditor of one hospital feels it his duty to scold each employe every time he makes an error. His day is a series of unpleasant events. He goes home at night tired and soured. His employes dislike to work for him. Perhaps that auditor could learn something about dealing with employes from the oriental custom of "saving face." This certainly does not mean that inefficiency should be condoned but rather that inefficiency can be corrected more effectively by making issues only of generalities, by correcting trends and policies and avoiding the unpleasantness attendant upon the endeavor to correct each individual error.

The department head has been given his authority because he has a job to do that is too big for one person to handle and he is given a number of employes to help him with that task. His relationship to these workers should be that of inspirer and leader. Much abuse of authority is the result of the department head's belief that he is a taskmaster, a detective whose purpose in the organization is to see that the employe works hard and doesn't "put anything over" on the hospital.

Perhaps the entire discussion of harmonious employe relations could be summed up in one word—fairness. Be fair by letting the employe know what is expected of him. Give him a fair and sympathetic audience when he has a complaint. Be sure that department heads are fair in their use of authority. Be sure that each employe feels he is being treated fairly in all respects.

Orientation Course for Employes

THE technic of absorbing the new employe into the organization may mean the difference between an interested, loyal worker and an indifferent, disloyal one.

The Norwich State Hospital gives a six hour orientation course for all new employes as soon as possible after they enter the service. Every employe is required to take the course of six lectures ending with an examination. There are no exceptions to this rule and nonattendance results in dismissal from the service unless sickness can be proved by a physician's certificate. The curriculum of this course is as follows:

General Administration—Dr. William A. Bryan, superintendent. This topic covers the plan of organization, the hospital program, policies and principles governing institutional management.

Merit System Rules and Regulations—Dr. V. T. Carr, assistant superintendent. This takes up the laws, rules and regulations that govern the application of the merit system under which all Connecticut employes work.

Elementary Psychiatry—Dr. Louis H. Cohen, clinical director. It is important that every employe, regardless of the type of work he does, should appreciate the fact that he is part of a hospital organization.

Business Administration — James J. Moore, business manager. If employes are to cooperate in the economical administration of the hospital, they must understand the general principles of accounting.

Food Service — Herbert Smith, steward. The steward covers details of the purchase, storage, distribution, preparation and service of food.

Tour of Hospital. The trip takes in laundry, kitchens, dining rooms, occupational therapy shops, sewing room and power plant.

Oral Quiz. An oral quiz is given at the close of the series and the result is incorporated into the service record of each employe.—WILLIAM A. BRYAN, M.D., *Norwich State Hospital, Norwich, Conn.*

Anesthesia Equipment Station

F. A. D. ALEXANDER, M.D., and GLENN STUDEBAKER

Director and Assistant Director, Respectively
Departments of Anesthesia and Administration, Albany Hospital, Albany, N. Y.

CONVENIENCE of equipment and supplies is important for any hospital department. When the activities of its members are spread over many rooms or floors, efficiency is obtained only by one of two means: by having every location of activity stocked with all the materials that may be needed at any time or by having these materials so located that they can be dispensed or obtained quickly when and where they are needed.

The variety, expense and bulkiness of modern anesthesia equipment preclude its being stocked in every operating room. Yet, having equipment, such as laryngoscopes, endotracheal tubes, aspiration and resuscitation apparatus, quickly and conveniently available may assure the life of a patient in an acute emergency. The most important factor in resuscitation during operation is the speed with which efficient resuscitative efforts are applied. If all the equipment is centrally located, a nurse or attendant can be sent for the necessary apparatus while the anesthetist remains to institute preliminary measures.

The question of safety of anesthetic agents, particularly with regard to the fire and explosion hazard, is at present attracting the attention of our most capable research, executive and clinical minds. Until there is a definite solution it seems reasonable to assume that such hazards as exist from the presence of these agents and equipment in operating suites would be lessened rather than increased by having them assembled in one place when not in use and by having the drugs stored centrally.

Gas machines kept haphazardly about the halls and rooms certainly run some risk of being inadvertently knocked over or broken; caches of ether and the explosive gases in otherwise unoccupied nooks in cabinets and supply spaces cannot be carefully accounted for. The restrictions against smoking and the use of open flames and potentially faulty electrical equipment are much more easily enforced in one spot than throughout the operating suite. There is added precaution, too, against cross infection by surer sterilization of airways, masks, tubing and other equipment.

Formerly wasted space, this modern anesthesia equipment station was redecorated and equipped at a total labor and materials cost of only $342.62.

We are convinced that economy is promoted by the decrease in loss of small equipment, such as metal airways which formerly were mislaid occasionally or were mixed with little used instruments. It is much easier to note the absence of equipment from a central station and to trace it at once.

Damage to gas machines from collision with stretchers and tables in the rooms and halls and from being knocked over is obviated. With all the equipment centrally assembled it is easier to carry out routine checks on its efficiency and so to discover minor breakdowns before they have become major ones. Finally, if the drugs, gases and supplies are kept in a central location, waste is minimized and the drugs are fresh, with little chance of deterioration or contamination.

Our setup at Albany Hospital, Albany, N. Y., is offered as an example of how a casual storage space on an operating room floor has been converted into an efficient, attractive, centralized anesthesia equipment station without prohibitive expense.

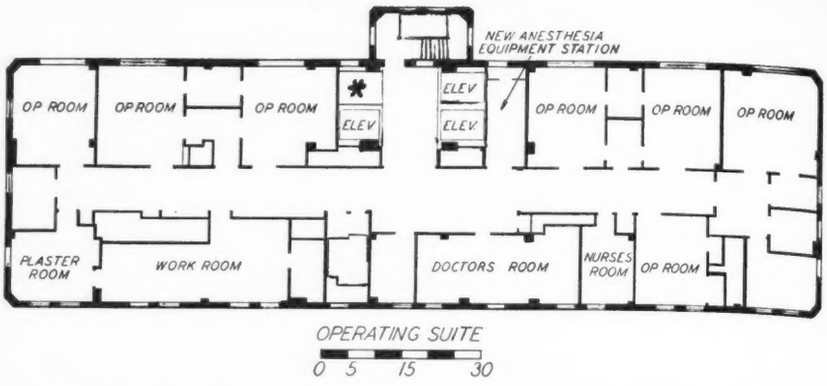
The operating floor is arranged with the elevator shafts, two on each side, occupying about the center of the long axis of the floor. Along this axis runs a corridor with operating rooms and workrooms on both sides. Behind the two eastern elevator shafts is a space, 7 feet 8 inches by 18 feet 8 inches, which opens onto the main corridor and which formerly was used for storing linen hampers, stretchers and empty gas tanks.

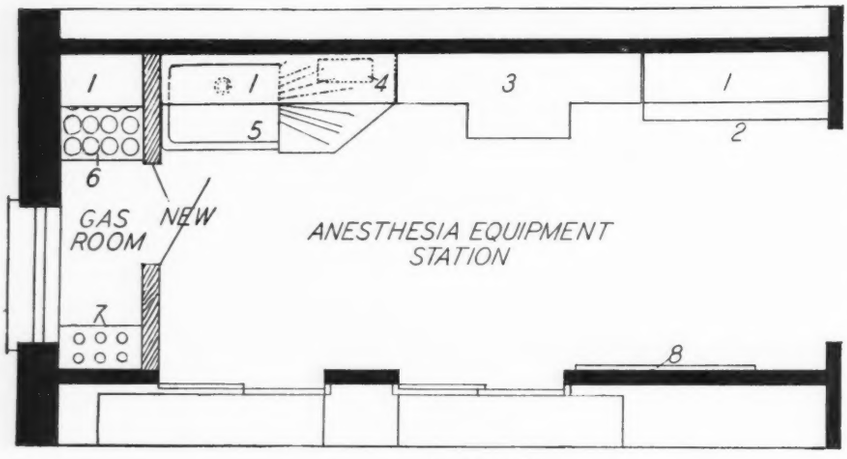
When the station was being planned it was felt that it should include: (1) a separate, enclosed space for the storage of the current supply of anesthetic gases, oxygen and ether; (2) a sizable sink with a drainboard large enough to serve as a workbench; (3) a small sterilizer to accommodate airways, endotracheal tubes, syringes and needles; (4) enclosed cupboard and drawer space with separate compartments for sterile syringes and goods, spinal and block needles and syringes, endotracheal equipment, anesthetic drugs, avertin mixing equipment

and trays, soda lime canisters, gas masks and connections, open drop equipment (masks, gauze and rubber eye dams), airways and miscellaneous equipment; (5) space for reserve equipment and little used apparatus; (6) desk space for chart recording and record keeping; (7) facilities for hanging recently washed rubber gas machine tubing and bags, and (8) open space to store gas machines where they would be easily accessible.

To satisfy the first requirement the radiator was removed from under the window and a plywood partition put in so as to enclose a space 2 feet by 7 feet 8 inches at the blind end of the room. This space, designated as the "gas room," was equipped with small standing racks, with holes fitted for the various gas tanks and with shelves for the storage of various agents. It opened into the main room by one door 2 feet 4 inches wide. The window is kept slightly open at all times and, while the partition would offer little protection if an explosion or fire took place in the room, there is sufficient ventilation to minimize the accumulation of gases from leaking tanks. Only a sufficient supply of the agents for current daily use is kept in this room. The major supply is kept in the basement of the hospital in a special compartment of the stock rooms.

The sink installed was a large one used only occasionally in another part of the hospital.





Above: Floor plan pointing out location of station. Below: Detailed plan showing arrangement of equipment.

The drainboard is of wood and is ample enough for regular needs.

The sterilizer is a small one of the electric type discovered elsewhere in the hospital and used only rarely.

The cupboard, shelf and drawer requirements were fully and efficiently satisfied by the installment of a common kitchen cabinet. This unit is attractive in appearance and provides ample space for all the requirements listed [in (4)] above, together with a small open worktable on which sterile packages can be put up and pentothal solutions made. Its dimensions are: worktable, 2 feet deep by 2 feet 6 inches wide; cabinet, 6 feet overall.

The remaining space on the east wall is taken up by a simple post office desk that offers ample space for the clerical requirements of the department. Over this space and over the sink and workbench at a height of 5 feet are additional simple shelves.

On the west side of the wall a narrow ledge was placed at a height of 5 feet and nails and hooks were provided for hanging such equipment as tubing and bags.

The space between the east wall built-in cabinet and the west wall is approximately 5 feet 8 inches and is ample for the storage of the gas machines.

The side walls of the room were painted light green, gloss finish, and the ceiling, oyster white, flat. In spite of having no outside window the room is remarkably bright and pleasant with one overhead lamp.

The expense involved was:

1. Erecting plywood partition, using an old door, building desk, making and putting up shelves and racks:

Labor	$75.65
Material	35.49
Total	$111.14

2. Removing radiator, installing salvaged sink, running hot and cold water and waste lines:

Labor	$37.00
Material	7.68
Total	$44.68

3. Installing light fixtures and electric sterilizer:

Labor	$38.60
Material	3.65
Total	$42.25

4. Patching and painting room and equipment:

Labor	$63.98
Material	12.59
Total	$76.57

Total Labor	$215.23
Total Material	59.41
Total	$274.64

To this was added the cost of the kitchen cabinet, $67.98, making a grand total of $342.62.

A. H. A. Convention Program

Atlantic City, N. J., Sept. 15-19

MONDAY, SEPT. 15

Pharmacy Section

Walter E. List Hall, 9:15-11:30 a.m.

Chairman: Worth L. Howard, Akron, Ohio; *Secretary:* Albert W. Snoke, M.D., Rochester, N. Y.

Address: The Feasibility of a Full-Time Pharmacist in a Hospital of Less Than 100 Beds, I. T. Reamer, Durham, N. C.

Address: The Purpose, Extent and Scope of the Hospital Formulary, Graham F. Stephens Jr., Evanston, Ill.

Address: A Common-Sense Materia Medica in the Hospital, Harry Gold, M.D., New York City.

Address: Economics of Purchasing Drugs, Solutions and Gases, Robert S. Fuqua, Baltimore.

Panel Discussion: Jack Masur, M.D., New York City, George U. Wood, Oakland, Calif. Topic: Should the Hospital Pharmacy Be Regarded as a Service Department, or Should It Be Regarded as an Income Department?

Anthony J. J. Rourke, M.D., San Francisco. Topic: What Constitutes a Special Prescription? How Can Such Prescriptions Be Controlled for Private and Charity Patients?

R. H. Stimson, Ph.G., East Cleveland, Ohio. Topic: What Capital Investment Is Necessary for a Pharmacy in a Hospital of 100 Beds?

Social Service Section

Emily Denton Hall, 9:15-11:30 a.m.

Chairman: F. Stanley Howe, Orange, N. J.; *Secretary:* Margaret Nichols, New York City.

General Topic: Integrating Social Service in the Hospital.

Address: From the Standpoint of the Doctor, Minna Emch, M.A., M.D., Chicago.

Address: From the Standpoint of the Nurse, Ruth W. Hubbard, R.N., Philadelphia.

Address: From the Standpoint of the Social Worker, Amy W. Greene, Baltimore.

Address: From the Standpoint of the Hospital Trustee, Mrs. Richard Meade Jr., Miquon, Pa.

Address: From the Standpoint of the Lay Worker (Volunteer), Mrs. William F. Campbell, Orange, N. J.

Address: From the Standpoint of the Administrator, James A. Hamilton, New Haven, Conn.

Discussants: Eleanor E. Cockerill, Brooklyn, N. Y.; John R. Howard Jr., Plainfield, N. J.; Frederick MacCurdy, M.D., New York City, and Mary M. Maxwell, Chicago.

Dietetic Section

Jessie Broadhurst Hall, 9:15-11:30 a.m.

Chairman: Lenna F. Cooper, New York City; *Secretary:* Morris Hinenburg, M.D., Brooklyn.

Address: Is the Special Diet Kitchen Necessary? Dorothy De Hart, New York City. Discussant: Emma Baughman, Brooklyn.

Address: A Comparison of Costs and Other Factors of the Selective Menu *Versus* the Single Menu for Ward Patients, Genevieve Coon, Albany, N. Y. Discussant: Henriette Pribnow, Philadelphia.

Address: The Pay Cafeteria for Personnel, Lute Troutt, Indianapolis. Discussant: Mary Harrington, Detroit.

Address: Food Waste, Helen C. Burns, Washington, D. C. Discussant: Marie Horst, New York City.

Address: The Dietitian in the National Defense Program, Mary I. Barber, Battle Creek, Mich.

Address: Food Cost Accounting for the Small Hospital, Mary K. Bloetjes, New York City. Discussant: Graham L. Davis, Battle Creek, Mich.

President's Session

Ballroom, Ambassador Hotel, 8-10 p.m.

Chairman: Benjamin W. Black, M.D., Oakland, Calif.

Addresses of Welcome: William Moore, governor of New Jersey, and the mayor of Atlantic City.

Address of the President: B. W. Black, M.D., Oakland, Calif.

Response by the President-Elect: Basil C. MacLean, M.D., Rochester, N. Y.

Presentation of the A.H.A. Annual Award of Merit to Dr. Frederic A. Washburn: Msgr. M. F. Griffin, Cleveland.

Ceremony of Destruction of the Bonds: Asa S. Bacon; Arthur C. Bachmeyer, M.D., Chicago, and Paul H. Fesler.

Presentation of National Hospital Day Awards: Albert G. Hahn, Evansville, Ind.

Reception: President, president-elect and officers of the association and their ladies in line.

TUESDAY, SEPT. 16

Administration Section II

William H. Walsh Hall
9:15-11:30 a.m.

Chairman: Leighton M. Arrowsmith, Brooklyn; *Secretary:* Louis Schenkweiller, Brooklyn.

Personnel in Hospitals

Address: Opportunities for Career in Public Hospital Management Through Cooperation of Civil Service and Merit Systems, William J. Ellis, Trenton, N. J.

Address: Personnel Policies With Reference to Selection, Grading and Dismissal in View of Present Conditions, A. C. Bachmeyer, M.D., Chicago.

Address: Wage Policies in View of Present Conditions, James A. Hamilton, New Haven, Conn.

Address: Out-of-Hour Activities, Mrs. Laura M. Smith, New York City.

Address: Selection of Employes for Service Industries, Kenneth Lane, New York City.

Address: Training of Employes for Service Industries, Mrs. Maude Boulden, New York City.

Tuberculosis Section I

Walter E. List Hall, 9:15-11:30 a.m.

Chairman: H. McLeod Riggins, M.D., New York City; *Secretary:* William H. Oatway Jr., M.D., Madison, Wis.

Address: The Development of New or Old Space for Tuberculosis Units in General Hospitals, William H. Oatway Jr., M.D., Madison, Wis.

Address: The Significance of Tuberculosis Infection in Employes of Hospitals and Sanatoriums, H. W. Hetherington, M.D., Philadelphia, and Harold L. Israel, Philadelphia.

Address: Tuberculosis Infection and Clinical Disease Among Student Nurses

—A Six Year Study, B. W. Pollak, M.D., and Samuel Cohen, M.D., Jersey City, N. J.

Address: Pulmonary Tuberculosis in Undergraduate and Graduate Nurses, George Ornstein, M.D., New York City.

Discussion: Theodore Badger, M.D., Boston; John Hayes, New York City, and Leopold Brahdy, M.D., New York City.

General Discussion.

Out-Patient Section

Jessie Broadhurst Hall, 9:15-11:30 a.m.

Chairman: W. T. S. Thorndike, M.D., Boston; *Secretary:* T. E. Broadie, M.D., St. Paul.

Address: Periodic Review of Economic and Social Status of All Out-Patients, Ray Amberg, Minneapolis. Discussant: Michael M. Davis, Ph.D., New York City.

Address: Out-Patient Rates and Costs, Abbie E. Dunks, Boston. Discussant: Edgar C. Hayhow, Paterson, N. J.

Address: Cooperation Between the Municipalities and Voluntary Hospitals in the Care of the Indigent Patient, J. Dewey Lutes, Chicago. Discussant: Frank E. Wing, Boston.

Address: Expanding Fields of Usefulness for the Out-Patient Department, E. L. Harmon, M.D., Valhalla, N. Y.

Hospital Service Plan Round Table

William H. Walsh Hall, 2-4:30 p.m.

Coordinator: E. A. van Steenwyk, Philadelphia.

Topic: Hospitals and Blue Cross Plans.

Panel Discussants: R. F. Cahalane, Boston; A. M. Calvin, St. Paul; J. D. Colman, Baltimore; R. M. Cunningham Jr., Chicago; T. S. Gates Jr., Philadelphia; C. W. Hunt, Harrisburg, Pa.; P. H. Keller, M.D., New York City; R. F. McCarthy, St. Louis, and S. D. Meech, Rochester, N. Y.

Tuberculosis Section II

Walter E. List Hall, 2-4:30 p.m.

Chairman: H. McLeod Riggins, M.D., New York City; *Secretary:* William H. Oatway Jr., M.D., Madison, Wis.

Address: The Rôle of the General Hospital in the Community Control of Tuberculosis, Dean B. Cole, M.D., Richmond, Va.

Address: Surgery in the Community Control of Tuberculosis, T. B. Aycock, M.D., Baltimore.

Address: Case-Finding Among Employes and Reemployability of Patients With Arrested Pulmonary Tuberculosis, Lauritz S. Ylvisaker, M.D., Newark, N. J.

Address: Employment Experience With Ex-Tuberculosis Patients. A Survey of Twenty-Six Years in Montefiore Country Sanatorium, Max Pinner, M.D., New York City, and Moe Weiss, M.D., Otisville, N. Y.

Discussion: Haynes Harold Fellows, M.D., New York City; David A. Cooper, M.D., Philadelphia, and F. Maurice McPhedran, M.D., Philadelphia.

Children's Hospital Section

Jessie Broadhurst Hall, 2-4:30 p.m.

Chairman: De Moss Taliaferro, Denver; *Secretary:* Margaret A. Rogers, Detroit.

Address: The Convalescent Home in Connection With a Children's Hospital, Winifred Culbertson, R.N., Cincinnati.

Address: The Criteria for Determining Eligibility for Admission of Free and Part-Pay Patients to a Children's Hospital, George von L. Meyer, Boston.

Moving Picture: The Relation of Public Schools and Children's Hospitals, Boettcher School and the Children's Hospital of Denver.

Lay Women in Hospital Service Session

Ambassador Hotel, Evening

Address: "V" Also Stands for Volunteers, Mrs. Harold Stanley, New York City.

Other speeches to be arranged.

WEDNESDAY, SEPT. 17

Hospital Service Plan Section

William H. Walsh Hall, 9:15-11:30 p.m.

Chairman: H. T. Sorg, Newark, N. J. Introduced by C. R. Burnett, Newark, N. J.

Address: Current Problems, C. Rufus Rorem, Ph.D., Chicago.

Address: Effect of Blue Cross Plans Upon Hospital Finance.

Address: The Experience of Business With the Blue Cross Plan, Philip C. Staples, Philadelphia.

General Discussion.

Construction and Mechanical Section

Walter E. List Hall, 9:15-11:30 a.m.

Chairman: R. E. Heerman, Los Angeles; *Secretary:* William P. Butler, San Jose, Calif.

General Topic: Safety in Defense Preparations in Hospitals.

Address: General Hospital Equipment as It Applies to Safety in Hospitals, George Buck, Trenton, N. J.

Address: Obstetrical and Nursery Equipment as It Applies to Safety in Hospitals, M. L. Busch, M.D., Chicago.

Address: Physical Therapy Equipment as It Applies to Safety in Hospitals, John Gorrell, M.D., Battle Creek, Mich.

Address: Anesthesia and Anesthesia and Surgery Equipment as Applied to Safety in Hospitals, J. Warren Horton, D.Sc., Cambridge, Mass.

Discussion: Fraser D. Mooney, M.D., Buffalo, N. Y.

Administration Section I

Jessie Broadhurst Hall, 9:15-11:30 a.m.

Chairman: O. K. Fike, Washington, D. C.; *Secretary:* Florence King, St. Louis.

General Topic: Accounting Control.

Address: From the Standpoint of Large Hospitals, Charles G. Roswell, New York City.

Discussants: Control of Purchases (Inventory Control), Cornelia C. Pratt, Orange, N. J.; Control of General Store Issues, Albert H. Scheidt, Dayton, Ohio; Control of Patient Charges, H. R. Mason, Washington, D. C.

Address: From the Standpoint of Small Hospitals, C. F. Golden, Sanford, N. C.

Discussants: Control of Purchases, Arthur Perkins, M.D., Newport News, Va.; Control of General Store Issues, Margaret Arnold, Danville, Ill.; Control of Patient Charges, W. B. Wiltshire, Richmond, Va.

Panel Discussants: Leaders: O. K. Fike, Washington, D. C., and Florence King, St. Louis.

The eight speakers will sit as a panel answering questions from the audience.

Lay Women in Hospital Service Session

Ambassador Hotel, 9:15-11:30 a.m.

Address: Canadian Women's Work in Defense.

Address: Red Cross Work in the Hospitals.

Address: Junior League Work in the Hospitals, Mrs. Richard Meyer, Poughkeepsie, N. Y.

Address: The Patient Library—a Hospital Window, Mrs. A. Victor Cherbonnier, New York City.

Address: Occupational and Diversional Therapy, Mrs. Harold M. Lehman, New York City.

Address: Hospital Shops, Mrs. Joseph T. Walmsley, Newark, N. J.

Lay Women in Hospital Service Round Table

Ambassador Hotel, 2-4:30 p.m.

Topic: The Women's Auxiliary.

Chairman: Mrs. Victor Harris, New York City.

Address: Organization, Functions and Relationships, Mrs. Victor Harris, New York City.

Address: Program and Projects.

Address: Fund-Raising Activities, Mrs. John G. Benson, Indianapolis.

Topic: Medical Social Service.

Chairman: Mrs. Harold Stanley, New York City, general chairman of the Women's Committee, United Hospital Fund of New York.

Visual Presentation: Medical Social Work Through Case Stories.

Questions and Discussions

Topic: Volunteer Aids.

Chairman: Mrs. W. J. Baker, Rochester, N. Y.

Topic: Hospital Shops.

Chairman: Mrs. Lawrence S. Heely, Plainfield, N. J.

Addresses: Relationship of Shop to Auxiliary; Shop Committee — Duties, Meetings, Services Afforded, Organization; Purposes and Policies; Volunteer Services.

Topic: Occupational and Diversional Therapy.

Chairman: Mrs. Harold M. Lehman, New York City.

Topic: Patients' Libraries.

Chairman: Mrs. A. Victor Cherbonnier, New York City.

Address: The Responsibility of the Women's Committee to the Patients' Library — How to Organize and Carry Through a Continuing Service, Mrs. F. Ritter Shumway, Rochester, N. Y.

Address: Training of Volunteers. Good and Bad Technics in Library Service, Mildred Schumacher, New York City.

Addresses: Specialized Library Services for Children; Specialized Library Services for Mental Patients, Isobel Collins, Waverly, Mass.; Specialized Library Services for Chronic Disease Patients.

Questions and Discussion.

Business Management Section

Walter E. List Hall, 2-4:30 p.m.

Chairman: Oliver G. Pratt, Salem, Mass.; *Secretary:* Scott Whitcher, New Bedford, Mass.

A panel discussion on the various phases of business management, such as admitting procedures, credits and collections, purchasing and stores, bookkeeping procedures.

Panel Discussants: Edgar Blake Jr., Gary, Ind.; Miriam Curtis, R.N., Syracuse, N. Y.; F. Stanley Howe, Orange, N. J.; Robert S. Hudgens, Emory University, Ga.; Everett W. Jones, Albany, N. Y.; Ivor Jones, Montclair, N. J.; Joseph G. Norby, Milwaukee; Alva E. Parker, Orange, N. J.; Anthony J. J. Rourke, M.D., San Francisco; Fred M. Walker, Charlotte, N. C.; J. Hasbrouck Wallace, New Haven, Conn.

Nursing Section

Jessie Broadhurst Hall, 2:15-4:30 p.m.

Chairman: F. Oliver Bates, Charleston, S. C.; *Secretary:* Jessie J. Turnbull, R.N., Pittsburgh.

Topic: Keeping the Graduate Nurse Abreast of Modern Nursing Advancements.

Address: The Active Graduate Nurse, Helen W. Munson, New York City. Discussant: Anna Taylor, Boston.

Address: The Inactive Graduate Nurse (for Local and National Emergencies), Mary Burr, New York City. Discussant: Claribel A. Wheeler, R.N., New York City.

Address: How Should the Small Hospital School of Nursing Be Fitted Into the Accrediting Program? Bernice E. Anderson, R.N., Newark, N. J. Discussant: Sister M. Laurentine, R.N., Pittsburgh.

Address: The Performance of Certain Clinical Procedures by Nurses in the Small Hospital, Regina H. Kaplan, Hot Springs, Ark. Discussant: Lake Johnson, Lexington, Ky.

Address: The Performance of Certain Clinical Procedures by Nurses in the Large Hospital, Evelyn M. Farrand, R.N., Philadelphia. Discussant: Helen J. Leader, Philadelphia.

Address: The Legal Aspect, Emanual Hayt, LL.D., New York City. Discussant: Roger W. DeBusk, M.D., Evanston, Ill.

Address: University Relations, Ruth Perkins Keuhn, R.N., Pittsburgh. Discussant: Robert E. Neff, Iowa City, Iowa.

Trustees' Section

Ambassador Hotel, 8-10 p.m.

Chairman: Raymond P. Sloan, New York City, Editor, The Modern Hospital; *Secretary:* C. R. Burnett, Newark, N. J.

Address: The Place of the Hospital in the Educational Structure of the United States and Canada, Willard Rappleye, M.D., New York City.

Address: Education of the Administrator, A. C. Bachmeyer, M.D., Chicago.

Address: Educating the Trustee, William Harding Jackson, New York City.

Address: Educating Women Workers, Mrs. Frank Vanderlip, New York City.

Address: Educating the Public, Armand Deutsch, New York City.

THURSDAY, SEPT. 18

Intern and Residency Section

William H. Walsh Hall, 9:15-11:30 a.m.

Chairman: Donald C. Smelzer, M.D., Philadelphia; *Secretary:* Frank R. Bradley, M.D., St. Louis.

Address: Status of the Interns and Residents in the National Defense Program, William D. Cutter, M.D., Chicago.

Address: Your Internship — Making It Worth While, G. Harvey Agnew, M.D., Toronto, Ont.

Address: How to Choose an Internship, Russell Oppenheimer, M.D., Emory University, Ga.

Address: The Nonteaching Hospital in Medical Education, Joseph G. Norby, Milwaukee.

Address: The Paid House Officer for the Small Hospital, Regina H. Kaplan, R.N., Hot Springs, Ark.

Panel Discussion: Leader: Malcolm T. MacEachern, M.D., Chicago.

Governmental Hospital Section

Walter E. List Hall, 9:15-11:30 a.m.

Chairman: Emanuel Giddings, M.D., Brooklyn; *Secretary:* Charles L. Clay, M.D., Miami, Fla.

Address: Centralized Control of Governmental Hospitals, William L. Coffey, Wauwatosa, Wis. Discussant: Gordon T. Broad, New York City.

Address: A Yardstick of Municipal Hospital Personnel, William Loughran, New York City. Discussant: James W. Manary, M.D., Boston.

Address: Functions of a Psychiatric Hospital in a Large City, Karl Bowman, M.D., New York City. Discussant: George P. Bugbee, Cleveland.

Address: Military Hospitalization in a National Emergency, Major Gen. Charles R. Reynolds (Ret.), Harrisburg, Pa.

Small Hospital Section

Jessie Broadhurst Hall, 9:15-11:30 a.m.

Chairman: Helen Robinson, Wauseon, Ohio; *Secretary:* William E. Barron, Washington, Pa.; *Coordinator:* John Steel, Pine Bluff, Ark.

Topic: Control of Surgery in the Small Hospital.

Panel Discussions: The Hospital Administrator's Responsibility in the Control of Major Surgery, William J. Donnelly, Princeton, N. J.; The Organization of the Medical Staff in the Control of Major Surgery, E. R. Murbach, M.D., Wauseon, Ohio; The Value of Adequate Medical Records in the Control of Major Surgery, Henry K. Baker, M.D., Flint, Mich.; Present Trends in the Control of Surgery in the Small Hospital, W. S. Rankin, M.D., Charlotte, N. C.

Topic: Public Relations in the Small Hospital.

Panel Discussions: The Need of a Public Relations Program in the Small Hospital, Alden B. Mills, Chicago, Managing Editor, The Modern Hospital; The Importance of Improved Service as

(*Continued on page* 68)

A.C.H.A. Program

SEPT. 13 to 15

SATURDAY, SEPT. 13

Registration
12:30 p.m.: Luncheon, Board of Regents
4 p.m.: Executive Committee Meeting

SUNDAY, SEPT. 14

10 a.m.: General Business Session of College Membership
2:30 p.m.: Convocation
Conferring of Fellowships and Memberships
Conferring of Honorary Fellowships
7 p.m.: Banquet
Address: This Revolutionary Age, Sir Wilmot Harsant Lewis, Washington, D. C.
9 p.m.: President's Reception

MONDAY, SEPT. 15

9:30 a.m.: General Educational Session
Address: The Administrator's Approach to Social Welfare Legislation, Fred K. Hoehler, Chicago.
Address: National Defense, Claude W. Munger, M.D.
Address: Changing Aspects of Organization and Administration, Robert W. Elsasser, New Orleans.
12:30 p.m.: Luncheon, Board of Regents
4:30 p.m.: Executive Meeting

TUESDAY, SEPT. 16

6 p.m.: All-American Hospital Administrators' Institute Alumni Reunion

Protestant Program

SATURDAY, SEPT. 13

Registration, 8:30 a.m.

Venetian Room, 9 a.m.-12:15 p.m.

Chairman: Rev. John L. Ernst, Detroit.

Devotions: Rev. R. V. Johnson, Toledo, Ohio.

Report of the Nursing Study Committee: Mary K. West, Los Angeles.

Address: The Church Hospital and Its Public Relations, Arden Hardgrove, Louisville, Ky.

Joint Committee Report and National Defense: Edgar Blake Jr., Gary, Ind.

Address: N.Y.A. in Hospitals, Elizabeth Sloo, Nashville, Tenn.

Report of the Commission on the Standards for the Work of the Chaplain and the Religious Work in the Protestant Hospital with special emphasis on "The Relationship of the Physician to the Clergyman," Rev. Seward Hiltner, New York City, and Rev. Otis Rice, New York City.

Summary of Morning Session, C. W. Munger, M.D., New York City.

Announcements and Adjournment.

Officers' and Trustees' Luncheon.

Venetian Room, 2-4 p.m.

Chairman: Edgar Blake Jr., Gary, Ind.

Round Table: Church Hospital Problems.

Discussants: M. T. MacEachern, M.D., Chicago, and Robert Jolly, Houston, Tex.

Business Session, 4 p.m.

Chairman: Guy M. Hanner, Colorado Springs, Colo.

Report of the Executive Secretary—Publications and Advertising, Albert G. Hahn.

Report of the Treasurer, R. E. Heerman.

Report of the Auditing Committee, C. S. Woods, M.D., Chairman.

Report of the Committee on Constitution and Rules, Rev. Herman L. Fritschel, Chairman.

Report of the Church Relations Committee, Dr. N. E. Davis, Chairman.

Report of National Hospital Day Committee, Millie A. Jacobsen, Chairman.

Report of Public Relations Committee, John H. Olsen, Chairman.

Report of Nominating Committee, Joseph G. Norby, Chairman.

New Business.

Adjournment.

Banquet, Venetian Room, 7 p.m.

President's Address, Guy M. Hanner.

Address: Rt. Rev. Theodore Russell Ludlow, D.D., Newark, N. J.

Recognition of Past Presidents: Presentation, M. T. MacEachern, M.D., Chicago.

SUNDAY, SEPT. 14

Morning Worship Service, 10 a.m.

Chairman: John H. Olsen, Prince Day, S. I., N. Y.

Chorus: Presbyterian Hospital, Philadelphia.

Address: Dr. Ernest G. Richardson, D.D., Philadelphia.

Testimonials and Experiences.

Report of Resolutions Committee.

Benediction.

A.H.A. Program

(*Continued from page* 67)

a Basis of Public Relations, Henry L. Goodloe, Hampton, Va.; Women's Auxiliaries and Junior Auxiliaries as Tools in Public Relations, William B. Sweeney, Willimantic, Conn.; Group Hospitalization Among Farmers as a Public Relations Medium, Helen Branham, Tupelo, Miss.

General Discussion From the Floor.

Topic: Accounting in the Small Hospital.

Address: The Value of an Adequate Accounting System in the Small Hospital, Stanley A. Pressler, Bloomington, Ind.

Address: The Relationship of an Adequate Accounting System to Group Hospital Service Plans and in Future Planning, W. P. Earngey Jr., Norfolk, Va.

General Discussion From the Floor.

Preparedness Session

William H. Walsh, Hall, 2-4 p.m.

Chairman: A. C. Bachmeyer, M.D., Chicago; *Secretary:* John N. Hatfield, Philadelphia.

Address: Preparedness and the Hospital, Winford H. Smith, M.D., Baltimore.

Address: The Nursing Profession in National Defense, Isabel M. Stewart, New York City.

Address: The Rôle of the Health and Medical Committee in the National Defense Program, James A. Crabtree, M.D., Washington, D. C.

Address: Practical Defense Measures for the Individual Hospital, A. G. Engelbach, M.D., Cambridge, Mass.

Address: The Rôle of the Hospital in Maintaining the Individual's Health as a Defense Measure, Everett W. Jones, Albany, N. Y.

Discussion: Basil C. MacLean, M.D., Rochester, N. Y.

Banquet and Ball

Ballroom, Ambassador Hotel, 8-10 p.m.

Toastmaster: Benjamin W. Black, M.D., Oakland, Calif., President.

Address: F. Harold Van Orman, Evansville, Ind.

Induction of New President.

Reception.

Annual Ball.

FRIDAY, SEPT. 19

General Round Table

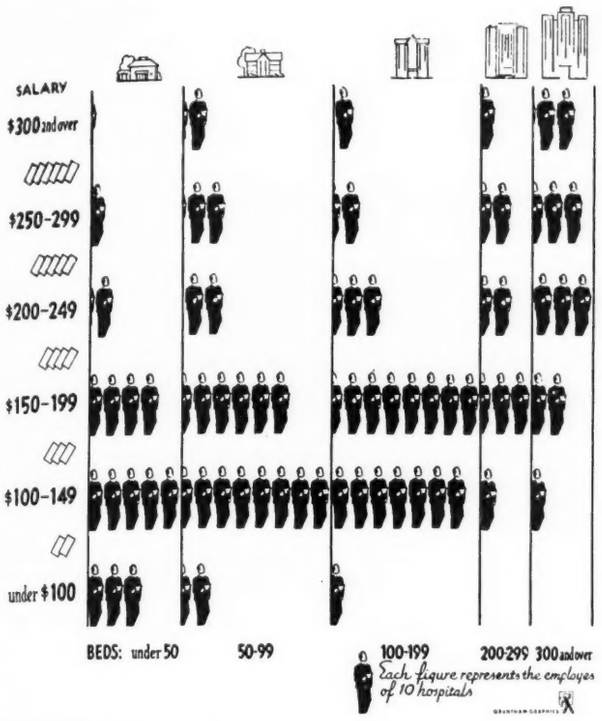
Ballroom, Ambassador Hotel
9:15-11:30 a.m.

Coordinators: Malcolm T. MacEachern, M.D., Chicago, and Robert Jolly, Houston, Tex.

Accountants and Bookkeepers

A Study of Salaries

ALDEN B. MILLS



Salaries of business managers and chief accountants show a wide range but in general are in accord with the size of institution served, as may be seen readily from the chart at left. Below: Map shows the geographical distribution of average salaries for this employe group.

BUSINESS managers or chief accountants in nongovernmental general hospitals of the United States and Canada receive an average salary of $180 per month and bookkeepers, an average salary of $101, according to the figures compiled in The MODERN HOSPITAL'S survey of the field. Both of the figures quoted are adjusted to include the fair cash value of whatever maintenance is provided.

For business managers, the salaries show a wide spread, according to the size of hospital. In hospitals of less than 25 beds, of which 19 sent in reports, the average salary of the business manager is $118. This increases to $144 in the 113 hospitals of from 25 to 49 beds that reported. In the 41 reporting hospitals that have 500 beds or more, the average salary was $271.

On a geographic basis the highest salaries for all sizes of hospitals are paid in the Mountain and Pacific states, with an average of $192. The East is close behind with $186 and the South averages $178. The average in the Middle West is $172 and in Canada, $160.

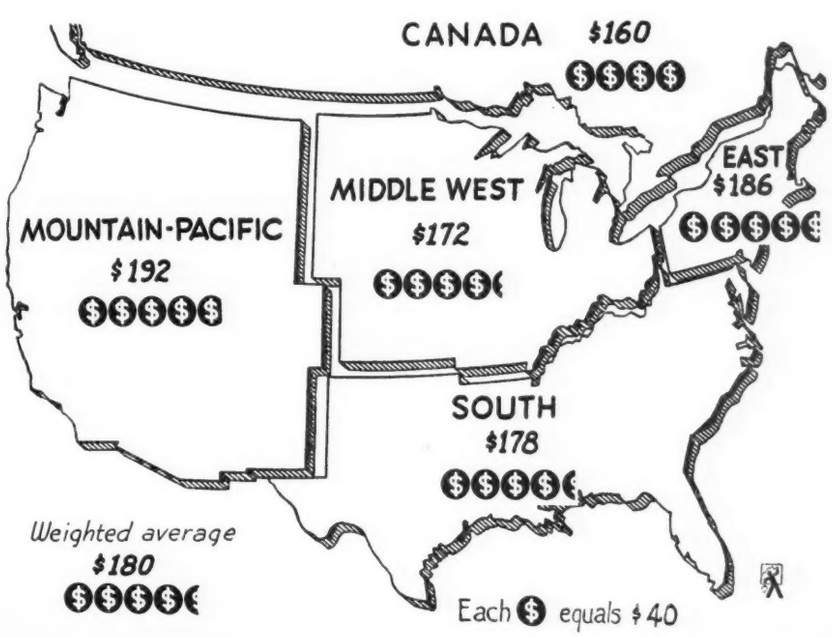
For all hospitals of less than 200 beds, the Mountain and Pacific states pay higher than other parts of the country, sometimes by a substantial margin, as in the group of hospitals with from 25 to 49 beds. Highest salaries in the hospitals of from 200 to 500 beds are paid in the Middle West. In the hospitals with more than 500 beds, the Eastern states pay $300 per month on the average, which is by far the highest average anywhere. Canadian salaries, in general, are lower than those in the United States for hospitals of the same size. In hospitals of 500 beds and more, however, the average salary in Canada is just at the midpoint, with two regions paying more and two paying less.

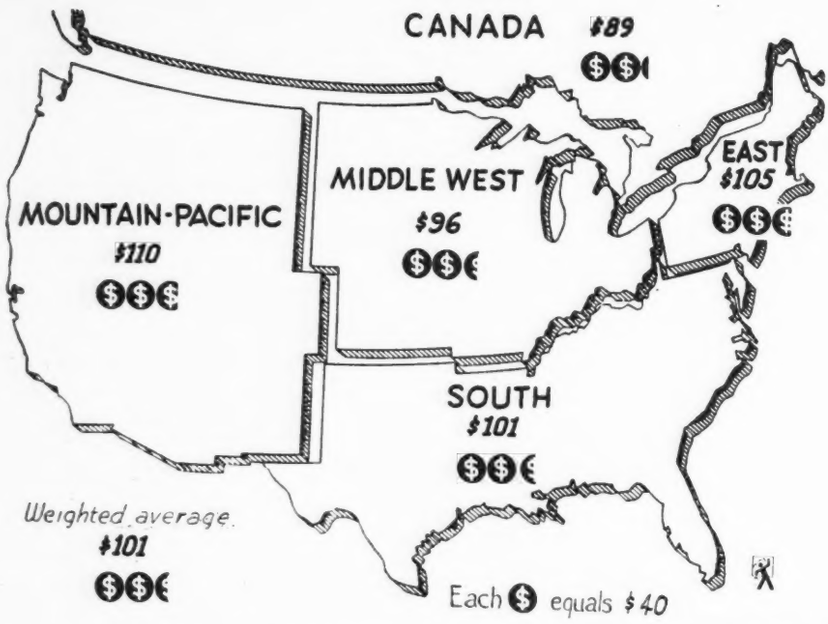
Of the 1244 hospitals sending in reports that could be tabulated, only 696 gave data on business managers

Average Monthly Salaries of Business Managers or Chief Accountants

	Bed Capacities of Hospitals							
	Under 25	*25-49*	*50-99*	*100-199*	*200-299*	*300-499*	*500 and Over*	*Total*
East	$ 85*	$116	$167	$165	$205	$235	$300	$186
Middle West	113	142	156	167	222	276	262	172
South	113	151	177	184	216	222	239	178
Mountain-Pacific	153	163	195	196	219	215	242	192
Canada	120*	115	126	149	184	211	252	160
Total	$118	$144	$169	$171	$212	$230	$271	$180

*One report received.





The geographic spread is indicated by an average of $89 for bookkeepers in Canadian hospitals and $110 for similar employes in hospitals of the Mountain and Pacific states. The high salaries paid in the Mountain and Pacific states hold for institutions of a variety of sizes. This area was highest in the hospitals of from 25 to 299 beds and those of 500 beds and more. In certain sizes of hospital, the difference was very marked, *e.g.* hospitals of from 100 to 299 beds. The East reported highest salaries for bookkeepers in only one category of hospital, those of from 300 to 499 beds.

A total of 981 hospitals filled out the data on salaries for bookkeepers, thus indicating that a much higher percentage of the institutions employs or chief accountants. It is probable that the other 548 hospitals do not employ anyone in this capacity. If this is true, only 28 per cent of the hospitals of less than 25 beds employ business managers or chief accountants. Thirty-seven per cent of those of from 25 to 49 beds employ such officers and 53 per cent of the hospitals of from 50 to 99 beds, 65 per cent of those of from 100 to 199 beds, 71 per cent of the hospitals of from 200 to 299 beds, 87 per cent of institutions of from 300 to 499 beds and 79 per cent of those of 500 and more beds employ business managers or chief accountants.

Average Monthly Salaries of Bookkeepers

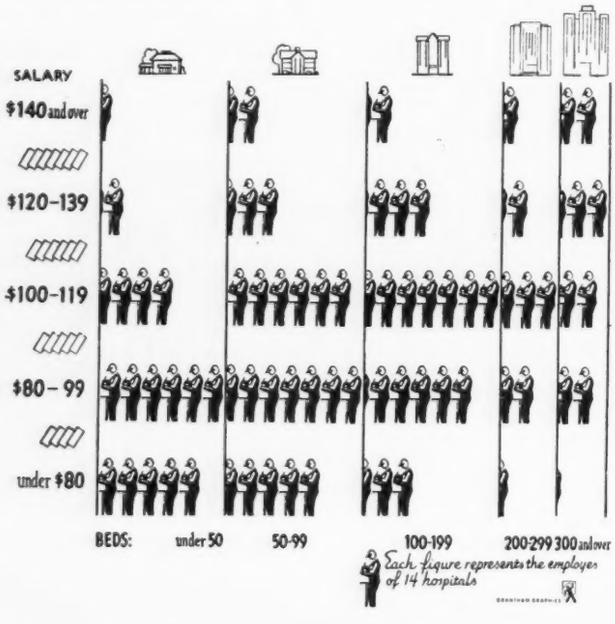
	Bed Capacities of Hospitals							
	Under 25	*25-49*	*50-99*	*100-199*	*200-299*	*300-499*	*500 and Over*	*Total*
East	$ 81**	$ 95	$101	$102	$105	$126	$133	$105
Middle West	89	84	92	102	109	120	125	96
South	102	88	98	107	107	114	114	101
Mountain-Pacific	84	95	106	115	129	125	147	110
Canada	100*	74	81	89	91	103	107	89
Total	$ 92	$ 88	$ 98	$103	$109	$120	$129	$101

*One report received. **Two reports received.

Turning now to the salaries paid to bookkeepers, we find them ranging from an average of $92 per month (including the value of maintenance) in the group of smallest hospitals to $129 monthly in the group of largest institutions. Curiously enough the lowest average salary, $88, is not, apparently, paid by the smallest institutions but was reported by the from 25 to 49 beds group, such personnel than employs business managers or chief accountants. Thirty-nine per cent of the hospitals of less than 25 beds, 65 per cent of those of from 25 to 49 beds and 84 per cent of the institutions of from 50 to 99 beds gave data on bookkeepers.

From the previous studies published in this series, it is apparent that bookkeepers receive salaries that are approximately equal to those of the chef or chief cook in hospitals of less than 100 beds. In the larger institutions, however, the salaries of the chefs or chief cooks are substantially higher than those of bookkeepers. The salaries of laundry managers, also, are about the same as those of bookkeepers in hospitals of less than 100 beds but these salaries go up much more rapidly than those of bookkeepers in the larger hospitals.

Bookkeepers receive less than most of the professionally trained personnel in hospitals and more than the maids, laundry workers and others in the unskilled groups.



Above: Map shows the average salaries paid hospital bookkeepers in the various sections. Left: Chart depicting bookkeepers' salaries in relation to size of hospital.

5000 New Friends a Day

C. RUFUS ROREM
Director, Hospital Service Plan Commission

DAY in and day out, a salaried force of 250 men is telling the story of the modern hospital as a health service center for the community. They are talking to groups in the corn country, shouting amid the whirr of machinery in the shops of the industrial East, explaining the values of hospital care by means of radio, motion picture, newspapers, group meetings. To the stirring history of hospital service in the Florence Nightingale tradition, these men are adding one more chapter, the miracle of the bill marked "Paid." They have grafted a happy ending to the hospital story by bringing into the plot a painless method of paying hospital bills.

These 250 ambassadors of hospitals are employed and paid by the 67 approved Blue Cross plans. Their job is essentially one of hospital public relations. As a result of their efforts, more than 2,000,000 people have joined the Blue Cross plans in the last year and perhaps five times that number have heard the hospital story. If you have heard a Blue Cross representative address a group of employes, you will recognize the basic truth of his talk:

"The hospital has stood for years as an agency ready to serve the needs of the people of its community. In the public interest, hospitals render care to rich and poor alike, hoping somehow to maintain budgetary balance at the end of the year. But service to the public comes first. Many a man who wanted to pay his own way into the hospital has found it impossible because he could not tell when he might need care or how much it would cost. Through the Blue Cross plans, which extend the service of the hospitals and which are approved by the American Hospital Association, any employed person can guarantee for his family hospital care when needed; by removing his need for charity, he can retain his self-respect."

To increase the effectiveness of these enrollment representatives and to bring the hospital story to greater numbers of people, the Hospital Service Plan Commission has developed and is now offering a public education program. The objectives of this program are:

1. To emphasize the medical and social value of the American hospital system, particularly the voluntary nonprofit institutions, which guarantees services to subscribers.

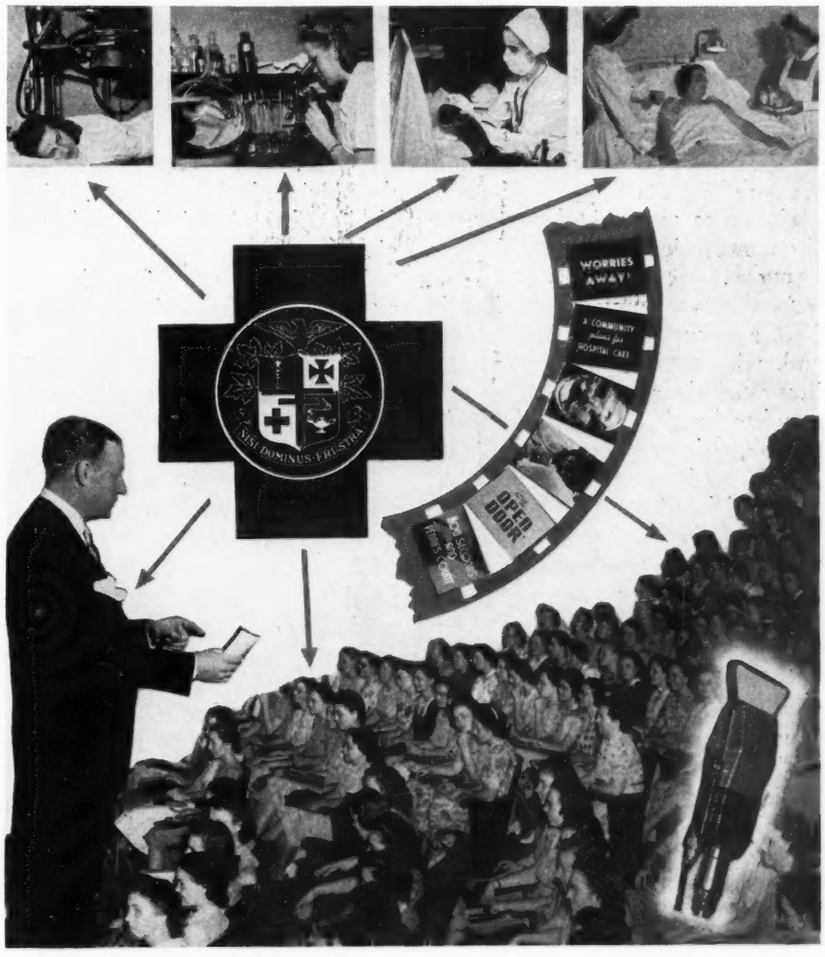
2. To popularize Blue Cross plans as the "American Way" to finance hospital care, as a combination of private leadership with social responsibility.

The program is directed to the general public and to all special groups of it—to the plans themselves, the hospitals, the medical profession, employers, employes, farmers, civic groups and governmental agencies. To all these groups will be told the story of group hospitalization and of the part each group plays in the growth and development of the service.

All currently popular and effective mediums will be used to reach the people: motion pictures, slide films, radio, sound transcriptions, newspapers, house organs, magazines, direct mail and promotional material, public address material, conferences and institutes.

Throughout the entire program, the emphasis is on the hospital. The plan, the educational agency, plays a secondary part.

In the radio program, for example, the convalescent patient says, "The



Last year some 2,000,000 persons became subscribers to the Blue Cross plans. With the impetus of the public education program conducted currently by the Plan Commission, this number should be increased appreciably for 1941.

hospital is a wonderful place." And the narrator, "The hospital *is* a wonderful place. But it costs money to buy all the expensive equipment." An appeal is made to the listener to join the Blue Cross plan so that he can help pay his share of the hospital costs.

In especially created motion pictures, the complexity of hospital management is skillfully described. The fact that a hospital is a home, a hotel, an educational institution, a life-savings bank, a place of healing is made clear to the audience through the use of sound and sight.

Aside from appreciation of their dependence upon hospital cooperation, the plans have an excellent reason to emphasize the hospitals rather than the plans. The plans actually furnish hospital care to one tenth of all subscribers, the one tenth who goes to the hospital each year. The man who doesn't use the service is the man who makes the plan possible. His one tenth goes toward the hospital bill of the unfortunate person who becomes ill.

The nonuser must realize the value of continuous protection. He must be made to feel a warmth and a strong sense of protection at the sight of his community hospital operating efficiently night and day, ready at the moment of his need to welcome him. The name "hospital," the word "nurse" or the sight of a hospital building should strengthen his feeling of security. To this man who is well, the idea of an intricate organization maintained for his rehabilitation, should need arise, moves him to continue his participation in the plan that guarantees him hospital care.

The commission's program of public education is already operating to build good will for the hospitals. During the life of the Interim Hospital Service Plan Commission, an expanded program will be drawn up and presented for approval at the Atlantic City convention. The new program will be merely an extension, an elaboration of the present activities; outlines of this program are available upon request.

Recent action by the board of trustees of the American Hospital Association indicates the possibility of joint operation of a public education program, the American Hospital Association and the plans contributing to the promotion of public interest and good will. Meanwhile, hospitals may derive considerable satisfaction from the knowledge that their services are better understood by the public and that the rapidly increasing enrollment reported by the plans will assure them an increasingly important rôle in the health program of the American people.

Regional Meetings Are Better

OLIVER PHILLIPS

**Secretary, Vancouver General Hospital
Vancouver, B. C.**

"WHAT have I to take home as a result of this annual convention?" one delegate queried at the close of a session of a provincial hospital convention. "I have listened to a number of prepared addresses and they have been good but these I can read in hospital journals. I have met new friends and have chatted with old but, considering all circumstances, what have I to take home and show my board as the results likely to accrue to our hospital as recompense for my expense account?"

Another delegate agreed, "The same thought has often passed through my mind. Is it not possible to obtain more out of our membership in this association and, if so, why do we not attack the matter seriously?"

Unlike so many similar conversations, something was done about the siutation.

At the succeeding convention, in 1939, a delegate prepared an address and, with the aid of a large map, illustrated the possible benefits that member hospitals might obtain by grouping the membership into regional conferences in given geographical locations.

One of the chief points made by the speaker was to the effect that the operations of the provincial association would not be lessened by this plan. In fact, he expressed the belief that if the regional conferences proved as beneficial as anticipated, nonmember hospitals would hurriedly seek membership in the provincial association so they could participate in the benefits of regional groups.

The convention endorsed the idea; within one year eight regional conferences were organized. At the 1940 convention a whole session was allocated to receive reports of the various conferences.

These reports disclosed:

1. Four conferences reported increases in revenues, one to the extent of $100,000 per annum, the six hospitals in this one conference all participating in the financial build-up.

2. Agreements were being reached in certain conferences creating uniform charges for special services, such as x-ray, laboratory and physical therapy.

3. All were working for the elimination of playing one hospital against another with regard to group contracts.

4. All conferences stressed the opportunity afforded for frequent meetings at which problems of purely local interest had been solved.

5. The firm front of the region controlling the majority of beds in the province had proved of inestimable benefit to hospitals in other regions.

A decision was reached that secretaries of regional conferences would forward a copy of minutes of meetings to the office of the provincial association. These minutes would then be circulated to all regions to the end that matters of interest satisfactorily handled in one region might assist another region with the same or similar problems.

This idea may not be new in other provinces or states. Hospital councils in large cities have been in operation for years and, undoubtedly, great benefits have resulted, but it is small hospitals that will receive the most benefit from the regional type of organization.

It is time that we come to the realization that the proper interpretation of the word "cooperation" is best found in two smaller words, "to help." If this is true, then in what other field than in service to the sick should the advantages of cooperation more logically be found to exist?

Housekeeper Plays Major Rôle

FRANCES C. LADD

**Administrator, Faulkner Hospital
Jamaica Plain, Mass.**

THE hospital housekeeper is responsible for the organization of her department and for the assignment and supervision of the entire personnel within the department. The department should have a close contact with the administrator or the assistant administrator. In this way many problems can be solved quickly and satisfactorily, while certain other problems interrelated with other departments must be solved around the conference table. All departments must be made to feel that they help to produce the service which the hospital renders as a whole.

A housekeeper, first of all, should be a good executive and organizer. She should be familiar with ordinary business practice, she should be able to judge textiles, she should have knowledge of the cleaning products and their advantages, she should be something of an interior decorator, she should have or develop the type of personality that will be an asset to her and the hospital in her contacts with co-workers and those who come under her supervision. She should develop qualities which make her a harmonious unit of the hospital's organization and a loyal aid to her employer. She is in a position to set her own limits in the direction and development of her work.

A housekeeper should always view her department in relation to the hospital in its entirety, realizing that no one department is an end within itself. Each department, in turn, must apply to other departments to complete its own function. The tendency to disregard the importance of willing cooperation with other hospital departments is perhaps one of the commonest weaknesses of department executives. The housekeeping department must cooperate in the sense that all departments have a part in the system of daily occupation, sometimes assisting others and sometimes seeking assistance, all in the interest and success of the hospital's schedule as a whole.

The trained housekeeper is in a position to develop employes that become valuable and contented workers, thereby reducing labor turnover. To maintain a sufficient number of employes in the department is an asset, so that cleaning, painting and repairing can be done when needed.

There are two principles that hold true with the majority of employes.

Working quietly behind the scenes, the housekeeper creates a good physical atmosphere and safeguards the institution's property. Her job is important and should be built up

One is that unless some form of stimulation is employed, the level of the work done by the employe is no higher than that which he considers sufficient to retain him on the pay roll. The other is that the amount of wages, strangely enough, seems to have no bearing on the quality of the service rendered. The housekeeper, then, must overcome these normal obstacles to obtain a high degree of cooperation and work from her employes.

Much dissatisfaction with employes is traceable to lack of a clear understanding at the time of employment. The housekeeper should have clearly defined policies governing her relations with employes and employes should have a definite idea of the policies concerning their relations with her.

Definite policies should be in operation on the following important points:

1. Salary, hours of work, time off duty
2. Definite outline of duties to be performed
3. Payment or nonpayment for hours of overtime work
4. Vacation time
5. Salary increase, based on length of service
6. Complete understanding as to whom the employe is responsible
7. Annual health examination and what this means to the hospital and the employe

The hospital will benefit if the employe is given instructions in such a way that he will have respect for the management and an enthusiastic interest in his work. This creates a feeling of security essential to good work and tends to give the worker the opportunity of checking his own work, a vital stimulus toward improvement. Too, it lends dignity to what the hospital expects from the employe and removes all misunderstandings.

Employes should become well acquainted with the hospital policies and schedule of duties assigned. It is advisable to follow the practice of the theater and plan to have an experienced worker available as understudy for the regular worker.

There is unquestionably room for improvement in the customary practice of paying a uniform wage to employes doing identical work regardless of the length of service and the quality of work done. In many hospitals the housekeeper finds there is little chance for promoting maids and porters and the method of paying housekeeping personnel does little to improve morale.

The form suggested by the American Hospital Association a few years ago would seem to be a helpful guide in arranging the scale of wages. There has been much discussion about the set wage for employes, which has many weak points. It either overpays in the beginning or underpays during the remainder of employment. There is no allowance for an incentive for better work. This plan is likely to result in a gradual decline of the quality of work done by employes of long experience who see inexperienced employes given the same reward that they have been receiving for years of service.

Would it not be of greater advantage to start the employe on the

minimum wage and increase this to the maximum over a period of one or two years? In certain instances, if an employe shows unusual ability and if the hospital can afford it, a promotion or a small increase in salary over the maximum might be in order. An increase in vacation time or the creation of an educational scholarship fund would tend to create a better feeling among the employes and, as a result, we would have more contented and efficient workers.

Safeguarding the health of all hospital workers is a good investment. In certain hospitals health examinations are given annually only to those connected with the dietary department. It has been our experience that it is far better to include the entire personnel since one person may infect another.

When this practice was first put into operation at Faulkner Hospital, it met with the wholehearted interest and appreciation of the entire group. We have a health officer in charge of this service, assisted by a nurse who gives part time in assisting with the details accompanying such service. Each year a complete chest x-ray study is made and a general physical examination is given; when conditions are found to require further study and follow-up, the employe is placed in the hands of the physician or surgeon recommended by the health officer.

Immunization Cuts Disability

During times in the year when the "common colds" are prevalent and much time is lost by many employes through this infection, immunizations are in order. Even though this service represents an additional expense to the hospital, we are safeguarding the health of the employe and the patient and in return have a system that is an asset rather than a liability.

Physical qualifications that should be checked before hiring an employe are age, marital status, walking ability and conditions of shoes and feet, hearing, eyesight, height and weight. Height is especially desirable in a porter or window washer and weight may be a handicap because of working space and the extra amount of energy that a heavy person must use. Mental qualifications may be checked by the age at which the applicant finished school but, of course, every good rule has its exceptions.

We should strive to maintain a high state of morale among the employes. Nothing seems to lower the spirits of workers or tends to create an atmosphere of unrest and uncertainty so much as the discharge of employes for no apparent reason or for what may appear as mere personal whims. However, the housekeeper owes it to the hospital and to herself to keep in mind always that permanence in employes is not an asset unless continued ability and efficiency accompany it. Often an able housekeeper has been blinded to the below normal results given in the work of certain employes through the development of preference for them created by a long association.

There is always room for improvement in the housekeeper's supervision of the employes in her department. A survey shows that the housekeeping department ranks next highest to and is exceeded only by the dietary department in labor turnover.

The good housekeeper, therefore, through her personality, knowledge of workers and sympathy will be an expert in obtaining loyalty from her employes. Workers respect and admire firmness in their superiors when it is associated with fairness and helpfulness. Employes are known to take pride in the knowledge and capacity of those directing them when these traits are genuine.

Efficient department heads have as few restrictions governing their employes as are consistent with good discipline but they enforce these rigidly. It is a mistake to have too many rules, for the less important will be ignored and the unobservance of these will lower the regard for the important ones, often resulting in a disregard for both.

A good executive knows when it is wise "not to see a minor infringement of rules" when the infraction may have been due to stress of a trying or busy day for the employe. Efficient department heads also make a practice of expecting much from their employes. Although there is not a tremendous amount of responsibility connected with a maid's job and a porter's job, both maid and porter will do better work if allowed to assume whatever responsibility may arise.

The housekeeper should strive to standardize the individual quality of her employes' work on as high a level as possible. She should strive to push the level even higher. It is a poor situation when the mediocre type of employe works with the efficient one. The housekeeper must either replace the inefficient ones, if she believes they are not capable of doing the work, or raise the quality of their work to that of the more efficient ones. Otherwise, she will find the work of the efficient ones lowering to the level of the others.

Variety of Duties

The duties of the housekeeping department are many and varied but also interesting and stimulating. They may include supervision of the laundry; close collaboration with the engineering department; purchase and inventory of linen; purchase and care of blankets; purchase and maintenance of mattresses; insect control; painting; the making of draperies, chair covers and ward curtains, and the care of beds. Added to these duties we still have the cleaning of corridors and the waxing of floors; the washing of walls and windows; care of the nurses' and employes' rooms; cleaning of the laundry, and the handling of emergency situations.

In the last twenty-five years these duties have increased markedly. In the past when most patients were hospitalized on ward beds, the matter of cleanliness only was paramount, but with the advent of private rooms, the patient's demand for pleasant and often luxurious surroundings has increased the duties of the housekeeping department to a marked degree.

The housekeeping department and the housekeeper are an important part of the hospital family and every hospital, small or large, will find it to its advantage to develop this department. The housekeeper is in a position to save in many ways and a clean, well-kept hospital gives the public a feeling of confidence. She is the person who works quietly behind the scenes, creating a good physical atmosphere and safeguarding the hospital property. Whether the occasion is a lecture or a tea party, she creates the setting.

This article is adapted from a paper presented at the 1940 New England Hospital Institute.

Medical Records on Parade

ROBERTA L. HESS

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Children's Memorial Hospital, Chicago

PRESENTATION of statistics in such a manner as to command attention, as well as to put a message across in the most effective language, is a matter worthy of study by alert medical record librarians. Every organized medical record department has a wealth of statistics available; much of the information would be of value and interest not only to the medical profession but to laymen as well if it were presented in a language known to them.

A simple graph showing some interesting comparison or contrast of cases, treatments or medications will often inspire the medical staff to make a complete survey of the information. Good graphs can do much to create interest in the activities of the medical record department among the other departments if they are displayed where they can be seen by everyone.

A graph is useless unless it meets several requirements. It must present interesting information; it must be simple, and it must have personality and appeal so as to command and hold attention.

We are all familiar with the more ordinary graphs. There is the line graph whose curves, peaks and zigzag lines convey the intended message. The main advantage of the line graph is its ability to portray minute and extreme variations in one presentation. However, its chief difficulty is that the information is not quickly assimilated; it requires study before the complete message is understood.

Many line graphs err because they do not follow the simplest rules of graph making. In order to present a true picture by means of a line graph, the horizontal and vertical axes must both start at zero, with the desired markings graduated from that point.

The bar graph is also satisfactory for presenting certain types of information. It does not achieve the accuracy possible in line graphs but it does gain more success in putting its facts forward simply and visually.

The most effective method of conveying information concisely and with the greatest possible interest is the "pictograph," so called because of its use of symbols or pictures to dramatize its message. Pictographs, with their rows of marching men or ships or animals, tell briefly and definitely some fact revealed by the arrangement of those symbols on the graph. The eye is caught at once and is held for the moment necessary to grasp the meaning.

Back of the seemingly simple pictograph are as much research and effort as go into any line or bar graph; perhaps, there is even more work in the preparation of a pictograph, for all unessential details are omitted and only the carefully digested and clearest data are given. Strict accuracy to the tenth of a per cent is not shown, but the necessary material is there, presented in the universal language of pictures, the one language that is comprehensible to everyone.

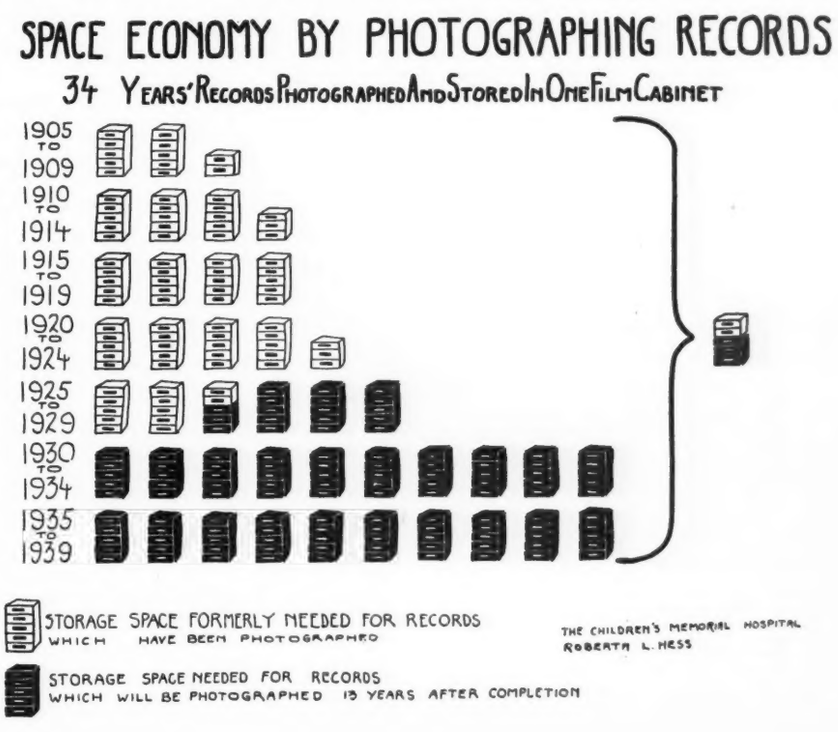
Perhaps the quickest objection to be made to the use of pictographs in the average medical record department is this: "What can we use for symbols to suit our needs? We're not artists!"

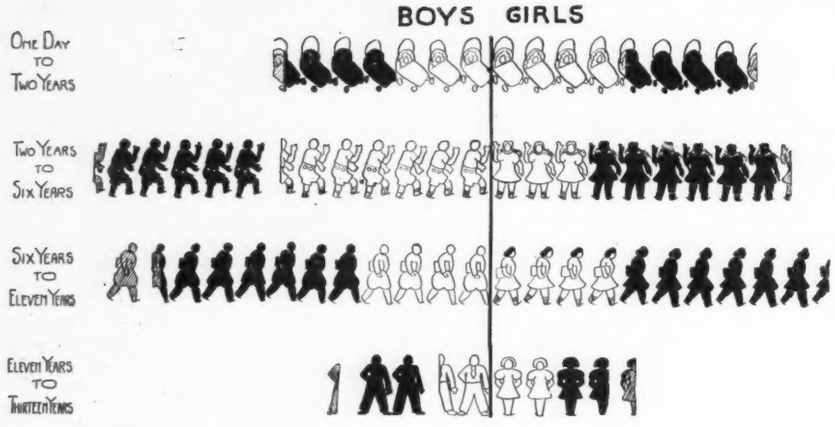
In reality, the difficulty is not insurmountable. Lacking anything else, diamonds, squares, circles or any geometric shape can be used to represent one unit. If there is anyone in the department who has even a slight talent for drawing, she can be of great help in producing simple symbols that can be cut out and then used as stencils for tracing. It is also possible to buy inexpensive pictograph symbols from a company that makes a business of pictorial statistics.*

The main requirement of a symbol is that it be clean-cut, free from detail and typical of the object it represents. An arrangement of three rectangles and two circles becomes a truck; a circle and an oblong rectangle become a tree; a few circles and lines become a gowned doctor; the possibilities are endless.

The pictograph should not be used to present too much information. For best results, there should not be more than 10 nor less than three lines of symbols on one graph; if a long span of time is to be covered, then

*Pictorial Statistics, Inc., 142 Lexington Avenue, New York City.





the time should be divided into equal periods, so that the representation of each line of figures will be the same as the other lines, with the symbols the same size and value. Confusion arises when different values are attached to the symbols on the same graph. If there seems to be more information than can be truly condensed into one graph, a series of graphs may prove to be the best answer to this particular situation in interpretation.

It is best not to have too many symbols on one graph; the statistics should be "boiled down," so that they can be represented by the least number of symbols without losing their meaning and proportion. It is not wise to use fractions of symbols unless fractions are unavoidable; in no case should less than half a symbol be used.

The actual printed information on a pictograph should be kept at an absolute minimum and should consist of one title, with a subtitle if necessary, plus the simple explanatory markings beside the symbol rows. Credit to source of information can be indicated in small print in one corner of the graph, since that information is of value to some of the people seeing the chart but does not need to be so prominent as to be confused with the actual statistics.

The accompanying graphs show the possibilities of pictographs in making an interesting presentation of statistics. They were prepared by an average medical record librarian and are Exhibit A in the case for pictographs that can be made in the average medical record department without help from professional artists.

The mere experience of making a pictograph is valuable in bringing out graph technic that is applicable to line graphs and bar graphs as well. The book "How to Use Pictorial Statistics" by Rudolf Modley covers intelligently and practicably any problem that one would encounter in the making of a pictograph.

Every medical record librarian will soon discover that the display of a pictograph in the record room or in the medical library, waiting rooms or on bulletin boards throughout the hospital will act as an incentive to create new interest in the activities of the medical record department.

To Stimulate Record Keeping

IN LINE with our policy of rendering stenographic aid to our physicians at all times in making up their medical records and in preparing lectures or medical papers, we try to have plenty of well-trained help in our medical record department. We encourage our personnel to take courses in anatomy and pathology in the nurses' training school conducted in connection with the hospital.

All patients' histories are taken by some member of the medical record department as soon after hospital entry as possible. When transcribed, these histories are placed immediately on the patient's chart. We make a point of getting a good history of the chief complaint, because all the doctors feel that this is an essential part of the history. Our doctors have been pleased with this help and a number of doctors from larger institutions have used some of our histories to encourage better history writing in their own hospitals.

We have had some trouble in getting reports of physical examinations from the doctors as soon as we felt we should have them. Aided by suggestions from the physicians, we made up a physical examination blank, had it printed and furnished each doctor with a supply. Because we found a large sheet inconvenient for the doctors to carry in their pockets, we prepared small sheets and had them made up in pads of 25, printed on both sides. When the physician is ready to take his physical examination he or his nurse takes out the little pad and checks the normal conditions, writing out any special comments. We have a copy of each doctor's normal physical examination; with this and the form sheet we are able to write out a complete and accurate physical, which the doctor signs.

We have only limited space in the medical office to keep our records, but we manage to have them in the active file for from four to five years; the remainder is stored in closed cupboards. We transfer a year's charts to the inactive list practically every year.

We also furnish help to our doctors in writing up progress notes and follow-up correspondence. Rather than an extravagance, we have found our personnel and medical record department an effective and almost indispensable service to the hospital.—JEANNETTE H. BLISS, *Mountain Sanatorium and Hospital, Fletcher, N. C.*

Modesty in Hospital Planning

J. J. GOLUB, M.D.

Director, Hospital for Joint Diseases, New York

MANY hospitals of relatively small size undertake or desire to undertake the training of physicians, nurses, dietitians and laboratory, x-ray and physical therapy technicians as well as laboratory research. Some hospitals engage or desire to engage in profit-bearing services for the convenience of visitors and personnel, such as a canteen, a restaurant or a gift, souvenir or flower shop.

The purposes of these activities are always well-meant. When they are chosen on the basis of undisputed usefulness and when their number, size and costs are kept within reasonable bounds, they add strength to the fundamental processes in which physicians and nurses are engaged, namely, the diagnosis and treatment of disease.

However, when selection is not based on these considerations, these facilities and services often successfully compete for hospital space with more essential services, consume the precious time and attention of the professional and administrative staffs and some of them may add considerably to the financial burden of the hospital.

Need to Redefine Purpose

What a hospital under such circumstances needs most is a redefinition of its aims, to be allowed by an appraisal of current values of all components that constitute the whole of hospital service.

The process of redefinition should be the kind that would result in a clear enunciation of the objectives the hospital seeks to achieve. In addition to a reiteration of the hospital's primary aim, the care of the immediate patient, due consideration should be given to the extent to which the hospital desires to devote itself to activities that are related to but not indispensable in the hospital's efforts of rendering medical and surgical care.

Having redefined objectives, the hospital authorities and the administrator would find it helpful and revealing to examine and weigh each of the components of the whole hospital service currently rendered. This is to be done not necessarily with the object of eliminating any of them but primarily to ascertain the current weight in terms of occupied space, of consumption of time of professional and administrative staffs, and of maintenance costs. Such measurement ought to result in ready identification of weighty components and their differentiation from those of lighter weight and thereby should reveal the relative position of each component in the scale of service value.

In the event that the results show imbalance in the light of the redefined hospital aims, there should follow a readjustment which would accord to each component what is considered to be a desired weight and a proper place in the scale of service value with a corresponding share of hospital area and equipment, a considered allotment of time of the professional and administrative staffs and an equitable portion of the operating budget.

In addition to strengthening the processes of medical and surgical care of patients, balanced and proportioned values would aid the hospital authorities and the hospital architect to plan satisfactorily all essential areas when undertaking the expansion or modernization of an existing hospital or when contemplating the erection of a new hospital. They would permit the application of building funds, which are usually limited, toward the erection of ample facilities required to meet adequately the hospital's primary aim, namely, the medical and surgical care of patients.

Hospital Is Teaching Center

Every hospital is a teaching center and every medical staff or house staff member is a student. Daily rounds, departmental, pathology and mortality conferences, follow-up clinics, the meetings of the clinical society and the journal club and the availability of current medical literature and books in the hospital's modest but up-to-date medical library are important continuation study courses for the hospital's visiting and house staffs. They enable the general practitioner and the specialist to maintain competence, to keep currently informed on the progress of medicine and thereby properly to discharge their professional responsibility to the public.

Some hospitals are especially qualified to participate in undergraduate and postgraduate instruction. Their bed capacity is large, their physical facilities are ample and their financial resources can meet the costs. In planning smaller hospitals, particularly in a community that already has one or more teaching hospitals or is not far removed from one that has them, teaching facilities may be safely omitted, especially when building funds are limited.

Question of Nursing Facilities

In the preparation of a building program for a new hospital, the question often arises as to whether it should include facilities for a school for nurses or merely residential and recreational facilities for the regular nursing staff. With this question, there is closely associated the ever-baffling problem: is it more economical to operate the nursing service with or without a school?

As yet, the question has not been answered satisfactorily. In general, the level of nursing costs depends on: (1) standards of service, *i.e.* whether a hospital can afford and is willing to furnish the desired three or three and one half hours of bedside nursing per patient in a twenty-four hour day or whether it must reduce the number to two and one half or two hours of nursing; (2) hours of work, *i.e.* whether nurses work forty-four, forty-eight, fifty-two or fifty-six hours a week, and (3) salaries paid to graduate nurses and attendants, on one hand, as against allowances, if any, made to student nurses.

Although accurate figures on costs are not available, the opinion prevails in the East that in the average hospital of 100 or 200 beds there is little difference in the cost of nursing service whether or not a school is operated.

A hospital should not have a school unless it has the assurance that it can meet the standards and requirements for general hospital service as set down by the council on medical education and hospitals of the American Medical Association and by the American College of Surgeons and that the school can become accredited by the appropriate authorities of its state. Nor should hospital authorities undertake the erection of facilities for a school of nursing unless the building fund is large enough to meet all costs necessary for the erection and equipment of a complete and modern hospital with all essential services plus a balance sufficient to meet the costs of erecting a nursing school building.

Only university hospitals and hospitals of sizable bed capacity affiliated with universities or specialty schools should undertake the training of dietitians and laboratory, x-ray and physical therapy technicians. Such training is best when it combines an organized series of didactic lectures with practical experience at the hospital. Satisfactory training in these fields requires an established curriculum, consisting of theory and practice, the two to be balanced and coordinated by interlocking the faculty of the university and the hospital staff qualified to instruct in these fields.

An ever-increasing number of hospitals of all sizes and all classes is adding research activities to the primary responsibility of caring for the sick. This, of itself, cannot be criticized. On the contrary, it is a commendable work. Hospitals know that the comfort and care given to patients today are due, in a large measure, to past scientific achievements of clinical and laboratory research. Many diagnostic and therapeutic measures owe their origin and development to the laboratory.

Two criteria make a hospital qualified to undertake research: one, money especially designated for the purpose and not at the expense of funds required for the essential services involved in the care of the immediate patient; the other, a staff qualified to undertake research. A hospital may have a proficient medical staff, highly qualified to diagnose and treat disease and yet it may be unprepared to pursue investigational work.

The development of research should not result in a simultaneous and corresponding retardation of development of other important hospital departments. Whenever there is need of economy in construction because building funds are limited, the hospital's first duty is to plan for those facilities that are essential for high-grade service.

To look at some of our new hospitals is a joy. If the visitor happens to be a modern, he is captivated by streamlined design and Pullman car compactness and utility. If he is an admirer of the older arts, he finds appeal in the classic and in period design and appointment.

The freshness of stainless steel surfaces, the lure of eyebrow-thin aluminum curves and the brightness of glass block walls, flanked by colorful murals on the history of medicine or picturing a child, relieved of deformity, happily throwing away its crutches, at once touch the artistic, cultural and humanitarian spirits of many hospital visitors.

These give the casual observer his first impression of the hospital. His admiration of the hospital is heightened by the "shoppe" service for flowers, bric-a-brac, canteen articles and quick lunch and by the beauty salon. Here he finds completeness.

Such interest, of course, is a tribute to the architect and to others who labored in order to give full expression to beauty, to sources of comfort and to utility. All would admit, however, that this kind of beauty, comfort and utility is of greatest interest to those who are on their feet.

The patient, for the greater part of his stay at the hospital, is in bed and confined to his room, requiring for speedy cure the beauty, comfort and utility that come from a clear view of natural landscape from his bed and chair; from a well-proportioned and tastefully furnished room; from timely service, cheerfully rendered; from peaceful atmosphere and professional tone; from good ventilation and sunshine; from the pleasant feel of well-laundered linen; from good food, properly prepared and attractively served, and from service rendered by qualified physicians and nurses, the proficiency of which is dependent upon essential professional and auxiliary physical facilities that are conveniently located.

WOMEN'S SERVICE GROUPS

A Hunt for Funds

• Looking for a novel way to raise money? Here is one that, while it may not appeal to some, has proved a sure producer in some parts of the country —Kansas, for example. It's a wolf or coyote roundup. The coyote, it seems, is killing sheep, chickens and turkeys by the thousands in the rural sections of the state. What is more logical, then, than to organize a "wolf hunt," which in addition to ridding the countryside of these pests will assure support for some pet charity?

It starts by issuing handbills or announcements in the local newspaper giving the location and the boundaries of the area to be encircled; also, the points toward which the lines will advance. The name of the manager is revealed, as well as the captains and the spots at which trucks will pick up the hunters—men and boys who proceed on foot, armed with shotguns. The animals thus bagged are sold and the proceeds turned over to charity.

Where do the ladies enter the scene? Well, one thing that hunters do bring back always is a healthy appetite. So the ladies serve the lunch, following the nimrods toward the center of the chase in cars.

Sometimes as many as 1500 hunters will participate, we are told. Should a law be passed providing a state bounty on coyote scalps, the benefits will be proportionately higher. Thus far, they are auctioned off for approximately $2 apiece.

There is one requisite to the success of the plan, of course. You must have coyotes.

For Maternity Department

• The most exacting technics in infant care can be carried out at Luther Hospital, Eau Claire, Wis., when the Women's Guild completes its fund for the purchase of 24 individual bassinets. The guild recently furnished funds for a delivery table, steel furniture for the delivery rooms, an incubator, a refrigerator, an electric bottle warmer and an autoclave.

They Shampoo, Too

• Among the various auxiliary organizations working for the Children's Convalescent Home in Westfield, N. J., is a group of colored women. Among other services, they come to the home twice each week to care for the hair of the little colored patients. Their combings and shampoos save the time of the professional workers and contribute much to the general happiness and personal hygiene of the children.

For Better Laboratory Service in Our Smaller Institutions

A WELL-EQUIPPED department manned by competent personnel seems to represent small hospital opinion regarding improved laboratory service, according to the answers recorded on 28 questionnaires received in this month's survey. Cooperation with near-by larger institutions in laboratory work is also looked upon with favor by several of these administrators.

In answer to the question, "Have you any suggestions as to ways that small hospitals can improve the quality of their laboratory service to patients?" some of the opinions expressed are as follows:

MRS. GERTRUDE W. FULLER, *Foster Memorial Hospital, Ventura, Calif.:* By employing competent help and by having an efficient person in charge so as to give satisfactory work to doctors on the staff at all times.

REGINA H. KAPLAN, *Leo N. Levi Memorial Hospital, Hot Springs, Ark.:* When small hospitals are handicapped by lack of laboratory facilities some arrangement should be made with a larger hospital whereby complete laboratory service could be rendered patients.

JOHN O. STEEL, *Davis Hospital, Pine Bluff, Ark.:* We are working on acquiring our own equipment and technicians and are endeavoring to obtain the part-time services of a pathologist and roentgenologist. We can thereby budget our expense fairly accurately and, possibly, give more and better service to patients at less cost.

A. A. AITA, *San Antonio Community Hospital, Upland, Calif.:* An adequately equipped department with well-trained personnel is necessary. The service should be complete, making available all procedures, and should extend over a twenty-four hour period each day. Laboratory work on part-pay and indigent cases should be encouraged instead of tolerated.

EDWARD ROWLANDS, *Christian Welfare Hospital, East St. Louis, Ill.:* Establish flat rates, comprehensive.

KATHERINE SMITS, *Peninsula Community Hospital, Carmel, Calif.:* I think the laboratory arrangements of any hospital should include prompt twenty-four hour service.

SISTER M. REGINA, *Michael Meager Memorial Hospital, Texarkana, Ark.:* This problem remains with the doctors and they should be encouraged to order the various tests, especially to help in diagnosing their cases; also, they should not interfere with the charges made.

MRS. GRACE HELLER, *Sioux Valley Hospital, Cherokee, Iowa:* We believe that all small hospitals should employ a full-time technician. We have had one for six years and are building up the service each year.

Most administrators agree the hospital laboratory is an essential department but the manner in which this service is conducted is as varied as are the personalities that control it

We inform the doctors in our territory concerning the service our laboratory renders and the price of all work. As most of the towns for which we do work are within a radius of 50 miles or less, we phone the report to the doctor as soon as it is finished, without charge. This service has brought a large amount of pneumonia typings, for which we charge $3.

CLAUDE SIMS, *Citizens' Hospital, Talladega, Ala.:* We employ a graduate technician who understands all phases of laboratory work and utilize the services of a pathologist as consultant.

R. L. BACON, *Pomona Valley Community Hospital, Pomona, Calif.:* Every hospital should operate its own laboratory and should have the services of a pathologist available.

JOSEPHINE BLALOCK, *Chicago Memorial Hospital, Chicago:* Friendly relations with some large, near-by hospital are invaluable in laboratory service. The technician should be well trained and competent.

HENRIETTA L. BIGNEY, *Johnson Memorial Hospital, Stafford Springs, Conn.:* To make and keep the patients and doctors "laboratory conscious" and to give them service at all times help a great deal.

ESTHER Z. MAXWELL, *Torrance Memorial Hospital, Torrance, Calif.:* We give twenty-four hour service; we make no charge on macroscopic tissue.

MRS. MARY E. KELLEY, *Mount Sinai Hospital, Hartford, Conn.:* We utilize the laboratory facilities of the larger hospitals in our community for rare or unusual tests which we are not equipped to do. Our patients, therefore, obtain the best type of laboratory service, made possible by the cooperation of these larger institutions.

F. JANE GRAVES, *Alton Memorial Hospital, Alton, Ill.:* One of the best ways to improve the quality of laboratory service to patients is to have a first-class pathologist. The salary paid may be considerably more than for one who has had less experience, but the service to the doctor and the patient means more than the money spent in salary, I believe.

DR. JOHN A. KENNEY, *John A. Andrew Memorial Hospital, Tuskegee Institute, Ala.:* When there are two or more small hospitals in the same city or section each of which is unable to employ a competent pathologist, it would seem a wise step to combine resources and share his services.

EDNA H. TREASURE, *National Homeopathic Hospital, Washington, D. C.:* Capable pathologists and technicians and suitable working facilities are the responsibilities of the hospital. Careless work cannot be tolerated in this department.

REV. CHARLES W. CURRY, *Warren A. Candler Hospital, Savannah, Ga.:* Seek to employ competent technicians, persons who are pleasant to

patients and who are interested in the general welfare of the hospital.

MARIE C. GOBEL, *Marion General Hospital, Marion, Ind.:* If a small hospital can get the services of a pathologist it does help greatly, especially for the technicians. We are rather proud of our laboratory because the hospital was built without this facility but when the demand of the city and county called for the addition of the department, the staff worked toward its planning and equipment.

To the initial question concerning laboratory service, "Do you have a full-time or part-time technician in the laboratory?" 26 hospitals replied that they employ the services of between one to three full-time registered technicians. Four institutions have full-time pathologists and nine utilize the services of visiting specialists or part-time pathologists.

Of the hospitals that do not have a pathologist's services available, interpretations are made by the registered laboratory technicians in five cases; five other hospitals send their work to some near-by larger city for interpretation, and five have staff physicians make interpretations. In some of these hospitals the work is combined, technicians and doctors doing the simpler interpretations while the tissue work is sent out of town.

Who Performs Necropsies?

When a full-time or visiting pathologist is employed by the hospital, necropsies are performed by him, according to the questionnaires. In the other institutions a staff member, usually the doctor or surgeon in charge of the case, performs the necropsy. Only one institution reported that necropsies are not performed at the hospital.

Unique among the answers is that received from John O. Steel of Davis Hospital, Pine Bluff, Ark., who writes, "All laboratory and x-ray work is handled on a commission basis by an approved laboratory located near by, which also has laboratory and x-ray equipment in the hospital. We have no expense of any kind and receive 25 per cent of all collections."

With regard to standard charges for urinalyses, Wassermann tests and complete blood counts the answers from these 28 hospitals were variable. The charge for urinalyses ranges from $2.50 to $0.50, 16 hospitals fixing their charge at $1. Although several institutions reported sending Wassermann reaction specimens to the state department of health, the average of charges for these tests run in the hospital laboratory was $3.32. The range of complete blood count charges was reported from $5 to $1.50, with an average of $3.19.

Flat Rates in Operation

Flat rates and routine tests are mentioned by seven of the 28 hospitals. "Our flat rate for all hospital patients includes two urinalyses, one complete blood test and one Wassermann for $3," writes Henrietta L. Bigney of Johnson Memorial Hospital, Stafford Springs, Conn.

Edna H. Treasure of National Homeopathic Hospital, Washington, D. C., says, "Our routine laboratory fee is $3. This includes complete blood count and two complete urinalyses."

"We make a $5 charge for each patient admitted who remains in the hospital more than forty-eight hours," F. Jane Graves, Alton Memorial Hospital, Alton, Ill., reports. "We do a routine urinalysis, complete blood count and Wassermann for this fee."

"Routine laboratory tests, including complete blood count and urinalysis, feces, smears and sputum, are done for $5 at our hospital," Claude Sims, superintendent of Citizens' Hospital, Talladega, Ala., reports.

"Our flat rate, forty-eight hour service includes everything except transfusions," Edward Rowlands, Christian Welfare Hospital, East St. Louis, Ill., states.

Esther Z. Maxwell, Torrance Memorial Hospital, Torrance, Calif., writes, "We do routine urinalysis, Wassermann and complete blood count on each patient. The charge is $4."

"We routinely do a complete blood count, sedimentation rate and Wassermann on all in-patients," A. A. Aita, administrator, San Antonio Community Hospital, Upland, Calif., asserts.

Questioned as to whether the laboratory operates at a profit or loss to the hospital, 18 of the 28 small hospitals queried reported a profit, two reported operating at a loss and four break even; four did not answer this question.

Supplementing this question, the following administrators opine:

ELLIS M. STUDEBAKER, *Bethany Sanitarium and Hospital, Chicago:* I believe that the laboratory should operate at a small profit as a margin of safety but its prime purpose should be service.

MRS. GRACE HELLER, *Sioux Valley Hospital, Cherokee, Iowa:* I believe the laboratory should show a profit, however small, so that new equipment may be purchased from time to time and the laboratory kept up to date. This cannot be done if the laboratory is consistently run at a loss.

JOHN O. STEEL, *Davis Hospital, Pine Bluff, Ark.:* Under our arrangement the hospital has a clear profit averaging about $100 a month.

What Other Administrators Say

AGNES F. FLORENCE, *Dixon Public Hospital, Dixon, Ill.:* We believe the hospital laboratory should operate at a profit and we have found it possible to do so without burdening any one patient.

DR. JOHN A. KENNEY, *John A. Andrew Memorial Hospital, Tuskegee Institute, Ala.:* I think that if the laboratory of the hospital breaks even we should consider it run successfully.

SISTER M. REGINA, *Michael Meager Memorial Hospital, Texarkana, Ark.:* Although we seem to operate at a loss, I believe a just profit should be made in this department to help toward the upkeep of the laboratory.

A. A. AITA, *San Antonio Community Hospital, Upland, Calif.:* Our laboratory operates at a small profit. This, I believe, is necessary if that department is to maintain the latest equipment with which to perform the newer laboratory procedures.

EDNA TREASURE, *National Homeopathic Hospital, Washington, D. C.:* We believe that a laboratory is a necessary part of the hospital and, regardless of the cost, should be maintained. We feel that this service to the hospital cannot be measured in dollars and cents.

Who Are These Trustees?

MALCOLM M. WILLEY

University Dean and Assistant to the President
University of Minnesota, Minneapolis

THE question of the functions that should be performed by lay boards of social agencies is one that has undoubtedly arisen in the mind of everyone who has ever served on such a board. Invariably, there will be at some time doubts in the mind of the board member leading him eventually to ask himself, "Why am I on this board and what am I supposed to do?" Presumably, lay trustee boards have functions that extend beyond formal approval of bills or generalized discussions of matters of trivial moment but it is not always apparent just what these functions are.

On this subject there has been, of course, perennial discussion. It has been stressed time and again that lay trustee groups should play an advisory rôle, that lay trustees should guide in shaping the policy in terms of which agency executives will do their work. The very fact that it is a lay board, it has been reiterated, should enable the membership to constitute a link between the administrator of the agency on the one hand and the general public on the other. It is because of ties with the larger public that the lay membership is presumed to have value as a policy sounding board.

Trustees Interpret the Agency

It is in this liaison relationship that a lay board can function with vitality and it constitutes, the conclusion is usually reached, the primary reason for its existence. Board members should be in position to interpret the agency to the broad public that is being served, whether by a hospital or any other social agency, and also to interpret that public to the administrators of the agency and guide them accordingly in the final determination of policy in all fields and with respect to all groups the agency touches.

Such generalized functions constitute the reason for the existence of the lay board. This is not the place to enter upon a prolonged discussion of the adequacy with which such functions may or may not be performed. Let it be said only that the potentialities for service that a lay trustee board presents to an agency and its administrators are not always realized. There are many reasons for this, ranging from indifference upon the part of an administrator himself to lack of leadership within the board. Most of these reasons have been analyzed many times. There is, however, one additional reason for failure of lay boards to function as they might.

Shaping General Policy

Remember that it is as a sounding board against which general policy may be formulated that a lay board can function constructively; general policy can be shaped wisely only if there is an understanding by board members of the agency and its activities, as well as an understanding of the community problems that the agency seeks to meet. Policy is invariably two-sided: it must balance internal agency considerations against the broader considerations that relate to the community setting in which the agency is doing its work.

One reason for the failure of lay boards to function adequately lies in the fact that their membership, instead of representing a full cross section of the public the agency is attempting to serve, actually represents but one fragment of that public. The inevitable result is that instead of having a wide range in point of view, out of which policy is to be formulated, the board has a selected point of view and a somewhat narrow one at that. How can a board formulate a well-rounded policy that is based on a full comprehension of public needs and attitudes, if the membership of the board that formulates the policy does not have representation that touches intimately all sections of the public that is involved?

Think back to the membership of lay trustee boards with which you are familiar. A cross section of many lay boards would be about as follows: there is a college professor, college administrator or a prominent public school man; there are one or two doctors, usually with distinguished practices; there is ordinarily a banker or employe of a financial house; one of the better known insurance brokers of the community is there, too; there is a successful business man or manufacturer, perhaps more than one; there are two or three women of social prominence; there is a clergyman, usually from a well-known church; there are two or three members who, although they have attended meetings for several years, are silent and unidentified; finally, there is the member whose name is on the list but who never has appeared.

Characteristics of Typical Board

There are certain characteristics that mark this board. First, it represents only one social and economic class in the community. Such representation invariably results in homogeneity of attitude with respect to community matters; there is uniformity in the way of thinking, a uniformity that represents a special focus in point of view. Second, as a group the board is relatively conservative in all matters, a fact that may in some instances stand as a barrier to open-minded acceptance of policy or action that might, in view of broad social needs, be worthy of careful consideration. In the third place, the board, member for member, is "eminently respectable," a fact not in itself to be deplored but the aura of a narrow respectability does on occasion tend to constrict one's point of view and color one's thinking in attacking problems of the type lay boards should sometimes be called upon to analyze. Fourth, perhaps by tradition, perhaps by train-

ing, the board members tend to approach social questions from the side of the sentimental; a "doing good" emphasis, rather than a cold and realistic study of the basic considerations involved, is characteristic. Last, this hypothetical board is uncritical or, if critical, critical in silence.

Of course, this description approaches a caricature, as any such generalized characterization must do, but it has lines of truth that are disturbing. It is disturbing because the homogeneity of thought and interest that results from the particular selection of the board members has precluded the injection of a broader base of ideas out of which well-rounded policy might be fashioned. If the original premise is sound, namely, that a lay trustee group should be a two-way channel of thought between the agency and the community, the fact that only one segment of the community is represented must invariably impede tapping all of the community sources that should be tapped to ensure a balanced understanding of community problems in relation to agency purposes. The difficulty is further magnified in the degree to which there is interlocking of agency directorates in a community.

A further question remains: if board memberships are too narrowly selected, who has been left out in the process? The answer is important because genuine community representation on the board cannot be achieved if significant groups of the public have no voice.

Usually absent from the roster are those who may be said to represent the laboring groups of the community. Often it is from these groups that the agency or institution is drawing its patients or its clients.

Unrepresented, too, are those who may be termed "the little fellows," the small business men, the skilled tradesmen, the "white collar" workers. These are men and women whose social prominence is not great, but whose attitudes and points of view may give significant insight into the work a social agency is doing in a community, whether for the sick, the poor, the handicapped or any others. How are the needs, the feelings, the thoughts of these groups to be tapped? How are their attitudes to be injected into policy discussions?

Likewise missing are representatives of social points of view that deviate from the orthodox mean represented by existing board members. The liberal lawyer, teacher, clergyman or social worker is not there. Yet a board, as has been suggested, can best perform its functions if into its deliberations go varied points of view.

It is not being assumed here that lay board members are expected to have a specialist's knowledge but rather that they bring to board discussions the more inclusive social or community considerations that bear upon the work the agency is performing. As stressed at the outset, the function of the board is to pool its knowledge and understanding of agency potentialities and community needs and problems to the end that sound and workable policies may be evolved. Therefore, it seems pertinent to ask, "For really effective functioning in policy matters and to ensure vitality, is the type of homogeneity of board composition now commonly found a desirable thing? Is it not conducive to a sterility or at least a rigidity of attitude which, while comfortable, may in the long run be detrimental to the best interests of the institution? In this fact is there not one fundamental reason why lay boards do not function as adequately as they might? Does not the composition of board memberships, leaving out, as it does, representation of entire groups in the community, constitute a serious shortcoming?"

It is the suggestion of these remarks that the attack upon the problem of satisfactory board activity may well begin, not with the customary discussions of h o w to awaken member interest nor with discussions of what superintendents and officers can do to stimulate board member participation, but rather with a critical examination of the selection that has gone into the lay board membership itself. If the membership on the board is all-inclusive and if it reflects a wide range of community needs and interests, the functioning of the b o a r d, through vital discussion, will pretty much take care of itself.

WHAT THEY ARE SAYING

The Ideal Trustee

• "The hospital board should be as broadly representative of community interests as possible. The days of the 'typical trustee' are fast passing."

Such is the opinion expressed by Barklie Henry, vice president of the Society of the New York Hospital. He proceeds to outline the ideal trustee in the ideal community, as follows: "He not only believes in the work; he is interested. He has not too many charitable entanglements. He looks on money raising not only as a necessary chore but as his chance to express enthusiasm for the work. He takes the initiative in finding ways to help for which he is best equipped and most interested. He takes the initiative in pressing for the solution of problems he sees."

National Health Program

• "In the whole country the past half decade has been noteworthy in public health ambitions, undertakings and achievements," declared Thomas Parran, surgeon general, in an address before the annual conference of the State Charities Aid Association, New York City.

"Federal legislation has helped to make it so. The Social Security Act in 1935 gave us title VI, a public health section designed to aid the states in providing more adequate public health services. Title V of the same act, administered by the Children's Bureau, provides for maternal and child welfare and for the care of crippled children.

"In 1937 the National Cancer Act was passed. In 1938 came the Venereal Disease Control Act.

"The power of the grant-in-aid made all these pieces of legislation strong, as well as of good intent. With this power we set about pulling together the public health activities of the country into the beginnings of a national health program, a program of national defense against the diseases that lessen a man's chance for happiness and security. In consequence, the U. S. Public Health Service has been called upon to meet acute problems arising out of mobilization and industrial expansion. This work has been helped by the good partnership developed between the federal government and the individual health authorities of the various states of the Union."

Instruments for the Power Plant

JOSEPH P. FAULKNER
Chief Engineer, Mountainside Hospital
Montclair, N. J.

IT GOES without saying that a hospital employs modern scientific equipment, but the heart of the hospital, the power plant, often suffers from the need of suitable instruments.

If a doctor conducting a physical examination said, "Your head is hot; you must have a fever," or "Your face is flushed, you have high blood pressure," it would sound foolish. It would be purely guesswork on his part.

Do you expect your engineer to operate his power plant without instruments or controls and to be satisfied with guesswork?

To diagnose his cases the modern doctor uses a thermometer to check temperatures, a blood pressure gauge to check blood pressure and a cardiograph to check heart action.

Now let us apply the equivalents of these instruments to the boiler. The thermometer will record the flue gas temperature so that at all times the engineer will know whether or not the boiler is effectively absorbing all the heat. The recording pressure gauge is used to indicate the drafts in the boiler, the oil or steam pressure. The cardiograph is comparable to a CO_2 recorder, which records the action of combustion.

You would not buy an automobile without an oil pressure gauge, a speedometer, a gasoline gauge and similar instruments, because at all times you want to know how your machine is performing. Yet, the hospital management often expects the supervising engineer to operate the power plant economically without any instruments to guide him. While it is true that these instruments are expensive, in a year's time they usually pay for themselves.

I feel that if an engineer requests proper equipment, he shows a genuine interest in his position and in the efficiency of the plant.

Here are some reasons why the instruments pay for themselves:

1. A flow-meter can measure hot water or steam being used by a laundry, or it may be used to record the total amount of steam developed by a boiler. The valve action of this meter is also a means for detecting leaks, although these should be discovered long before they are large enough to show on the meter.

To illustrate my point with figures, a leak has developed in a steam pipe. This is 1/32 inch, the steam pressure in this pipe is 100 pounds and 1000 pounds of steam costs $0.60. This leak of 1/32 inch will waste 3160 pounds of steam. In one month's time it will cost the hospital $1.90. If this leak were ¼ inch, in a month's time the steam waste would amount to 202,000 pounds, which would cost $121.20.

Peak efficiency in the power plant can be maintained only with proper equipment and diligence in its use, Mr. Faulkner contends. In the accompanying article he argues the case of steam instruments for the boiler

2. A CO_2 recorder will give the operator a true index of combustion efficiency.

If your boiler was operating at 7 per cent CO_2, the fuel loss would be 13.1 per cent. When the CO_2 is increased to 14 per cent the fuel loss will be 0.83 per cent. You can readily see how important this instrument is as a fuel saver in a large institution.

3. A boiler flue gas temperature recorder, used to record exit gas temperature, shows at all times whether or not the boiler is absorbing the heat. If the temperature is high, this indicates that the boiler tubes are dirty or that the baffles are leaky. A 1/32 inch coating of soot will cause a fuel waste of 23 per cent.

4. A steam pressure recorder is an important instrument as it will eliminate any dispute as to whether the pressure has been maintained constantly. Constant steam pressure is of vital importance to hospitals, owing to the many departments using steam equipment at different pressures.

Little consideration is given to contraction and expansion of steam piping in relation to constant steam pressure. For example, in an institution with several wings covering several acres, all buildings may receive their steam supply from a central power plant with steam mains running underground. When long runs are involved, there is probably an expansion joint or expansion loop. If steam is delivered to the steam mains from the boilers at 100 pounds' constant pressure and if the steam pressure recorder is watched closely so as to maintain constant pressure, there will be a pressure drop at the end of the steam main, depending upon the length of the main and whether it is properly pitched and drained.

For the same boiler with pressure delivered to the main at 100 pounds but without recording devices, pressure may be 100 pounds at 6 a.m.; at 8 a.m., however, when the hot water, laundry and kitchen steam load is at its peak, the pressure in the main will probably drop to 60 pounds. And this condition may well not be discovered for some time.

This difference in pressure is playing havoc with the pipe threads, fittings and flanges. On sleeve expansion joints it is wearing out packing, not to mention loss of efficiency in departments requiring steam at constant pressures.

We Solved Our Water Problem

MORRIS SORKIN

Business Manager, Sanatorium of the Jewish Consumptives' Relief Society, Denver

AN ADEQUATE supply of pure uncontaminated water is a first consideration of any institution. Many hospitals purchase water from the city or town of their location, in which case the annual water bill may amount to a considerable part of the budget. When conditions are favorable for obtaining water from an artesian well, any institution is in a position to introduce marked economies in procuring its water supply.

At the Sanatorium of the Jewish Consumptives' Relief Society, located in Spivak, near Denver, Colo., the old artesian well from which water was pumped by a 45 h.p. steam-driven compressor had lost slightly more than half its capacity while the demand had constantly increased, making necessary a substantial increase in the amount of water purchased. Our investigation indicated the desirability of digging a new well and installing a turbine pump.

An examination of the logs of other wells within a radius of 3 miles and consultation with a qualified engineer gave fair assurance that sufficient water to meet our requirements was available at a depth of about 800 feet, whereupon complete specifications for the construction of the well and installation of the pump were drawn up. On the basis of these specifications, the construction contract was awarded.

The well, as finally constructed, provided for a 12 inch casing to a depth of 152 feet and a 10 inch casing to a depth of 421 feet. The 12 inch and the 10 inch casings were run down to a solid footing and cement was poured around the outside of the casing to shut off any impurities that might seep in from above this level. The inside casing, 8¼ inches in diameter, was run down to a depth of 820 feet.

In digging the well, samples of the earth strata at different levels were stored in jars and carefully recorded. When water-bearing sands were found, the inside casing was perforated at the sections indicated.

This installation is unusual in that the turbine pump is equipped with a combination drive. It consists of a vertical hollow shaft motor and a right angle drive head, directly connected to a horizontal steam turbine, all of which permits flexibility of operation and provides a stand-by in case of repairs to either driving unit.

During the heating season, about eight months of the year, the pump is operated by the steam turbine and right angle drive. The cost of pumping during this time is extremely low, since the exhaust steam from the turbine is turned into the heating system. During the four summer months (from the middle of May to about the middle of September), or nonheating season, when the demand on the well is at its peak, the pump is operated by the 25 h.p. motor. This method of drive has resulted in a reduction of more than 65 per cent in water cost over previous years.

The turbine assembly is set at a depth of 450 feet and furnishes more than 150 gallons of water per minute against this head. The standing level of the water in the well is 374.6 feet below the surface. When the pump is operating there is a drawdown of about 30 feet, thus giving us an additional 46 feet of water from which to draw. During all of 1940 this well met all our water requirements.

The water as pumped comes in at a temperature of 72° F. and shows only 2.25 grains of hardness. This has resulted in further economies in soap and alkalies in our laundry.

Vacuum Container for Cracked Ice

ALBERT H. SCHEIDT

Administrator Miami Valley Hospital, Dayton, Ohio

A NEW type of vacuum ice container has been installed in Michael Reese Hospital, Chicago. The new containers, when seen in their original form, were vacuum cans for carrying hot foods. With minor adjustments, including the addition of a spigot at the bottom of the can for draining off ice water and the elimination of unnecessary clamps at the top to hold down the lid, these cans readily lent themselves to use for storage of cracked ice in the duty rooms, diet kitchens, utility rooms.

The outstanding advantages that accrued to us from such a program were:

We had been using a brine system with the large boxes originally provided for that purpose. We found that we were keeping cracked ice in the ice boxes with the result that every time one of the nurses wanted ice, the refrigerator had to be opened, thereby displacing a considerable amount of cold air.

Under the new arrangement, the care of the ice box becomes equivalent to that of having an ice chest on the floor. However, the vacuum can has many advantages over the ordinary ice chest in that at the same cost it is possible to accomplish better conservation of the ice. Furthermore, the unit is small, a decided advantage where space is at a premium.

The unit may be obtained with a stainless steel lining, providing a sanitary interior. Because of the simplicity of its makeup, we have every reason to believe that its length of life will be materially greater than that of the ordinary type of chest.

HEINZ Offers Hospital Dieticians A NEW FREE "Food And Diet Counselor" SERVICE

H. J. Heinz Company — maker of the famous 57 Varieties — announces the creation of a new "Food and Diet Counselor" service, available to all hospitals in the United States free of charge

THROUGH its "Food and Diet Counselor" department, Heinz brings you a new approach to the many feeding problems faced by progressive hospitals today. New ideas for menu planning, food buying, general kitchen supervision and the multitude of other services that contribute so much to the comfort and satisfaction of your patients, are available to you at any time. Or if any specific diet problem is bothering you, Heinz "Food and Diet Counselor" staff will be glad to help you work it out.

Experienced Staff

Organizer and head of this new service is Laura Means Thayer, familiar to hundreds of hospital dieticians through her activities in the American Dietetic Association. Her experience dates back to her association with Hahnemann Hospital, Philadelphia, where she held the post of Administrative Dietician for two years, following which she engaged in restaurant work as food supervisor for a large chain of cafeterias. Feel free to call on the Heinz "Food and Diet Counselor" at any time. Simply write H. J. Heinz Co., Dept. MH-9-A, Pittsburgh, Pa.

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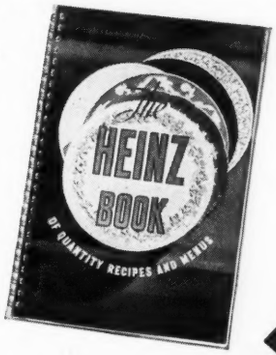
• In the new Heinz Quantity Recipe Book you'll find hundreds of recipes for wholesome, economical dishes that yield up to 75 servings. This exceptional book is yours for the asking. Simply fill out coupon below and mail today.



H. J. HEINZ CO., Hotel and Restaurant Division
Dept. MH-9—Pittsburgh, Pa.

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HEINZ 57 VARIETIES

Those Extra Nourishments

The pendulum of dietary opinion, according to this symposium, appears to be swinging toward the positive side of the oft-debated question: to serve or not to serve between meal nourishments. Some of the difficulties involved in putting a system into operation are discussed here

ALTHOUGH they present numerous problems involving both dietary and nursing departments, in-between meal nourishments are being served in the majority of voluntary hospitals and there is no tendency to curtail this service. To the contrary, the list seems to be increasing in many institutions. As one dietitian puts it: "This practice takes care of the patient who needs small frequent feedings as well as the one who wishes to eat or to drink just to be doing something."

This situation, revealed in a recent study made in hospitals throughout the country, supports the general belief that extra nourishments play an important part in the comfort and treatment of patients, not only adding more calories and fluid to the diet but also many times obviating the necessity of intravenous injections.

In governmental hospitals a different situation prevails, three meals with no nourishments between being the usual rule. Because of the necessity for observing the strictest economy and for eliminating all luxuries, this would seem justified, assuming that the diet is adequate, with possibly hot milk and crackers available at bedtime to forestall any discomfort in the interim of an early evening meal and breakfast.

Fruit juices, milk or chocolate milk rank first on the list of favorite refreshments. Then come tomato juice, ginger ale, coca cola, fresh fruits in season, ice cream and water ices, buttermilk and cultured milk, custards, gelatins, broth, gruel, cookies and tea. Central service, that is, all nourishments prepared and served from a central kitchen, is proving far more satisfactory and economical than sending supplies to the floors to be prepared and served there by the nurses. The plan, of course, must depend upon the setup in the individual hospital.

Speaking from actual experience with both types of service, Charlotte Sloan, formerly at Stanford University Hospital and now associated with the Park Lane Hospital, Salinas, Calif., states emphatically that nourishments can be served economically from a central serving kitchen.

"For years we served nourishments averaging 300 a day at a food cost of 4½ cents per nourishment," Miss Sloan asserts. "When we changed from sending supplies to the floors where the nurses prepared and served the nourishments to using the central kitchen where one woman prepared and served all the in-between nourishments we not only saved hours of nursing time but also cut in half the cost of food materials.

"The serving of nourishments," Miss Sloan continues, "should present few problems in a well-organized hospital if served from a central kitchen by maids trained for this work. The practice of ordering unnecessary nourishments that are wasted or consumed by the nurses and the difficulty in having the containers used in the service returned to the kitchen are the usual problems. If the nursing supervisors are cooperative, these problems are solved. If not, there is little the dietary department can do except to check a little more carefully.

"At one time we sent a list of patients and the type of diet ordered for them to the nourishment kitchen every morning so that the maid could check with her orders, preventing orders being sent to empty rooms, to patients with no diet or to patients on a special diet. This was a great help, although it took the time of one of the maids to do this extra checking.

"Many more problems present themselves in the old method of sending the supplies to the floors and letting the nurses prepare and serve the nourishments. First, there is the waste of the nurses' time. Each nurse will spend from ten to fifteen minutes in the service kitchen. Multiply this by the number of nurses on the floor and you will find you are wasting hours of valuable nursing time. Second, the nurses will leave the kitchen untidy, with water, food and soiled dishes about, requiring the time of a kitchen employe for cleaning. Third, they will be wasteful of supplies, thus increasing food costs and, fourth, the finished product will vary from poor to good according to the skill of the individual nurse who prepares it."

Miss Sloan sees a solution to the nourishment problem in the coffee shops that are being instituted in many hospitals. These will solve other problems, too, she believes. "The between meal nourishment for the regular diet patient might well be charged to the patient; with a coffee shop and fountain operating continuously, a profitable service would result. The nourishments for all other patients could be ordered similarly and carried by the hospital."

A pioneer in central nourishment service is Sophia L. Morris, dietitian, Newark Beth Israel Hospital, Newark, N. J. Miss Morris serves nourishments three times a day to private patients and leaves fruit juice as ordered on the ward floors. All nourishments are made up in the central unit by a maid who works every day from 7 a.m. to 4 p.m. and who passes nourishments to private patients at 10 a.m. and 2 p.m. Night nourish-

ments are delivered to the floors by the student nurse in the diet kitchen and served by the nurses at 8 p.m. Any request for nourishment during the day is taken care of by the nourishment maid.

There is no question of the tendency to serve everybody nourishments, regardless of the diet, according to Marion D. Floyd, chief dietitian, Massachusetts General Hospital, Boston.

Miss Floyd recites some of the problems entailed by the dietary department: limiting nourishments to special diets only; getting nourishments passed out at the proper time of day (often they are distributed right after meals); providing an acceptable kind of nourishment (some patients object to flavored milk and certain fruit juices); getting the nourishments passed if nurses are busy; getting the glasses collected if ward helpers are busy, thus preventing their being washed in time for use at the meal hour. Although the dietitians control the preparation of the nourishments in the diet kitchen and the amount sent each ward and require that the order posted in the kitchen be signed by the nurse at the time of giving nourishments, there are many slips.

In the Baltimore City Hospitals, Baltimore, where Helen Schmit serves as dietitian, nourishments between meals are served only to those patients for whom the doctor prescribes such treatment and there is a tendency to eliminate such extra feedings. For example, extra nourishments were provided in the tuberculosis unit until a year ago, when it was found that patients ate their meals much better when they were discontinued. Now the only feeding given other than at mealtime is ½ pint of milk at 8 p.m., that is, unless nourishments are individually ordered by the physician and such instances are limited.

To offset any pangs of hunger in those five or six hours between breakfast and dinner, I. Leslie Hunter, head of the nutrition department at Bridgeport Hospital, Bridgeport, Conn., encourages all who can to visit the dining room where they are served milk or cocomalt and a variety of crackers. Those with jaded appetites and who are in need of special nourishment must have it ordered by a doctor and approved by the nursing school and administrative offices. Included in the midmorning nourishment is buttered bread with a choice of three sandwich spreads, namely, meat or cheese spread, sweet spread and a vegetable such as sliced tomato, along with a nourishing beverage.

"Many avail themselves of this midmorning nourishment," Miss Hunter explains. "Midafternoon nourishments are also allowed, but few bother to take them, the menu being the same as in the morning, with the addition of tomato juice. Nourishments are supervised by the dietitian who is in charge of the dining rooms."

At Robert Packer Hospital in Sayre, Pa., a plan has been devised which not only satisfies the patients, according to Mary E. Lenker, dietitian, but is economical from the standpoint of budgeting. "Nourishments are provided for every patient in the hospital who is able to take them," she reports.

We Aim to Please

STELLA LINDEMANN

Dietitian, Christian R. Holmes Hospital, Cincinnati

THE foremost aim of the dietary department of Holmes Hospital, a 52 bed Cincinnati institution that serves private patients only, is to satisfy every food idiosyncrasy and to make each tray as individual as it would be in the patient's own home. Adjusting the menu to the individual depends upon the daily contact of patient and dietitian.

The attitude of the whole department is one of cheerfulness and kindness. The personnel consists of the head dietitian and her assistant, colored cooks, porters and maids. The dietitian plans the menus, controls the entire purchasing, cooking and serving of food, the hiring and discharging of employes and is responsible to the superintendent for the efficiency of the food service.

Everything is done to make the patients as happy as possible. If one has a birthday, a small cake is sent on the evening tray. On special occasions novelties are an added attraction. At Easter, colored eggs made into flowers, chickens and rabbits appear on the breakfast trays; at noon, daffodils from the hospital gardens and iced cup cakes with green coconut and small candy eggs represent an Easter basket. Holly tied with red ribbons, individually wrapped fruit cakes, poinsettia salads and Santa Claus candles create Christmas atmosphere. Patients enjoy this attention and remark about it to their friends. In this way, we help to promote good will for the hospital.

Patients on regular diets receive a colored menu card on the breakfast tray. The menu is selective and each one may check his preference. This card is collected later in the morning by the dietitian, who offers suggestions if any changes are desired. By using a selective menu, the food cost is not increased; this program minimizes the number of special orders and too full a garbage pail.

Central tray service for a 52 bed hospital is satisfactory. Linen covers and napkins, gaily multicolored china and well-kept silver are used on the trays. Beverages and soups are sent on the food carts in vacuum containers and are added to the trays from the floor kitchens.

Each item is carefully checked by the dietitian before the colored porter dressed in an immaculate white suit or the maid in a yellow uniform with white apron, collar and cuffs carries the tray to the patient. Twenty trays can be served in four minutes, so there is an assurance that "the cold foods are cold, and the hot foods are hot." Thus, the dietary department assumes complete responsibility for food service and friction with the nursing staff is lessened.

The personnel menu is planned to meet the preferences of the majority and yet to keep within the limits of the budget. Salads and desserts, for example, are identical for patients and staff. By serving a variety of dishes, the menu becomes less monotonous and the staff becomes more appreciative.

When Witches Play

WHERE, oh, where, are we to get attractive tray favors, something new and unique? Here we are facing a calendar dotted with "red letter" dates starting with Halloween and not so much as an idea of what to do or who is to do it. With a depleted staff and the necessity of employing almost anyone who is able to work, extra services that always have meant additional burdens now become obstacles appearing almost insurmountable.

Perhaps friends of the hospital in auxiliary organizations will help out. It's worth trying anyhow. Sometimes individuals in other departments of the hospital are especially skilled in creating clever favors out of practically nothing, using odd bits of this and that and making them seem important, at least to the patient and his visitors.

Mabel MacLachlan, director of the department of dietetics and housekeeping at University Hospital, Ann Arbor, Mich., tells us that the occupational therapy department is a real help in devising amusing articles for the children. Outside organizations, such as the King's Daughters, girl scouts and the schools, also send her favors.

At La Crosse, Wis., Lorene Kulas, dietitian, Grandview Hospital, gets help from the Junior Red Cross, which sends in favors made by the school children.

Sister Mary Lucille, housekeeper at the Good Samaritan Hospital in Cincinnati, is extremely artistic and makes all sorts of clever favors, according to R. Alberta Hughes, administrative dietitian. The best part of it is that these cost only about 2½ or 3 cents apiece. She buys her materials from a paper house and often the salesman will give her odds and ends that can be worked up effectively.

When the Salem Hospital, Salem, Mass., was small, Edith L. Hoadley and her staff made all the favors, but as the hospital grew it became impossible to find time for this activity. For the last two years, therefore, the Ladies' Aid has come to the rescue, furnishing favors for 14 special days. The ladies do not make the favors themselves necessarily, but the chairman of the favor committee asks different church associations and clubs in the city to be responsible for certain days. For example, the Business and Professional Women's Club did the honors for Thanksgiving and the guild of the First Unitarian Church helped out at Christmas.

With the fall season already here, there is no time to be lost in planning what to do for Halloween, our big day in October. Let's see what others have done with success. Sister Mary Lucille, for example, has received many compliments for her shock of wheat. She cuts yellow cellophane in long shreds; tan or yellow crêpe paper can be substituted at less cost. One and a half inches from the top she ties it with fine cord. Then she runs through the center an orange pipe cleaner and fastens it on the bottom to an oval piece of cardboard. A candy pumpkin pasted on the cardboard gives a realistic touch. This can be used as either a place card or a favor.

The date cat described by Lorene Kulas is always good for a smile.

Holiday favors devised by these dietitians are clever and easy to make. Some of them may appeal to you as effective ways to interest and amuse your patients

Pipe cleaners are used for the body, the legs and the tail. The head is shaped from a date, using small pieces of pipe cleaner for the eyes and ears. Toothpicks form the whiskers.

A jack-o'-lantern made from an orange is also simply done. First, the top is cut off for the cover. Then, all the pulp is removed from the cover and the inside. The eyes, nose and mouth are cut out of one side and a parsley stem is inserted in the cover. If you would be daring, place a small birthday candle inside, but beware lest it smoke. Miss Kulas tried them once for a table decoration but they smoked badly and had to be extinguished.

In addition to such favors as these, she suggests jack-o'-lantern cookies, which are nothing more than regular round sugar cookies, covered with orange frosting, with raisins for eyes, nose and mouth. Or possibly a jack-o'-lantern salad will fill the right spot on the menu. Take a half peach and turn the outside up. With a knife make slots for the eyes, nose and mouth, inserting raisins.

In Paris, Texas, Mrs. M. B. Stolz, dietitian at the Sanitarium of Paris, is forever contriving ways of making something from nothing—practically nothing, anyway. Take her Halloween favor, for example. All she asks is an apple, an all-day sucker, black crêpe paper and white notepaper. A skeleton face is painted on the white paper; for this the artist does not have to be too proficient. This is pasted on the front of the sucker and the sucker is stuck into the apple. The crêpe paper is cut 10 inches wide, covering the apple.

A strip of crêpe paper 2 inches wide with notches cut in the end for fingers is twisted tightly and tied around the neck, leaving a little margin for the neck ruffle. The final touch is a place card tag cut from the white notepaper and tied to the hand.

More original even than this favor for Halloween is Mrs. Stolz' ear of corn made with popcorn and an applicator stick. Aside from the corn and the applicator stick, all that is required are green cellophane paper in two tones and white notepaper for the place cards.

The popcorn is stirred in syrup and rolled onto the sticks, leaving about 2 inches of the stick as stalk. The cellophane paper is cut into lengths about 2 inches longer than the whole stick. The width must be slightly more than half the circumference of the corn so that the leaves will overlap. Two leaves, one of each shade, are twisted slightly at the small end and firmly at the stem end. Then comes the place card, which is merely tied on.

We don't want to use up all our best ideas for Halloween when there is Thanksgiving coming, which calls for the same general color schemes and effects. So, let's see how many different and original ideas we can think up between now and next month.

Control of Kitchen Fires

LEONARD F. MAAR
Safety Research Institute, New York City

KITCHEN fire hazards fall into one of two general categories: those due to faulty equipment or installation; those created by workers. The former can be controlled almost absolutely, but no one yet has designed a robot worker capable of doing its job day after day without lapse of judgment.

When flame and heat are used as freely as they are in kitchens, the menace of fire never can be entirely discounted. A study of fourteen fires in hospital kitchens revealed that eight originated in flues, hoods or from grease spilled on stoves. One fire of this number was caused by lightning and the other five were of undetermined origins that probably were associated with cooking equipment.

It is significant that the common causes of fire, careless smoking, spontaneous ignition and defective electric wiring or equipment, do not appear in this list, though if the number were much greater one or more probably would show up.

Perhaps the most frequently encountered kitchen fire is that occurring in hoods over ranges and grills or the flues venting the hoods. Accumulations of grease condensed from smoke and cooking vapors lodge there and unless cleaned regularly they invite fire. Sparks or heat may ignite the grease and cause a nasty blaze. For this reason, ventilation flues and stacks are or should be thoroughly insulated from the adjoining structure to prevent the spread of fire.

Cooking fats spilled on stoves also account for a number of fires. Thermostatically controlled deep fat fryers eliminate this danger.

Grease fires burn violently, giving off volumes of heavy, acrid smoke. Water is of no avail on them. They require an extinguisher that will smother them by cutting off or by diluting the oxygen needed to support combustion. Considering the quantity of cooking fat that may be involved in a hospital kitchen fire, such an extinguisher is needed quickly.

The chemical fire extinguisher can be used to combat such fires without delay. Four types are approved for use on grease fires: the vaporizing-liquid, foam, loaded-stream and carbon dioxide types. Foam and loaded-stream units generally are of 2½ gallon capacity. The vaporizing-liquid extinguishers generally are of 1 or 1½ quart capacity. The carbon dioxide extinguishers are manufactured in various sizes and have a range of about eight feet. The 2½ gallon units will discharge a stream for a distance of from 30 to 40 feet and the vaporizing-liquid extinguishers, operated by pump action, will expel a stream for a distance of about 20 feet, depending upon the operator. Two 1½ quart vaporizing-liquid extinguishers are rated as being equal to one 2½ gallon unit in extinguishing power.

The extinguishers should be placed near the range hoods so they can be used without delay. The kitchen staff will not be concerned about maintenance of these extinguishers, as that is part of the engineer's responsibility but each member of the staff should know how to use them. These extinguishers may also be used to control fires in ordinary combustible materials that may occur in or near the kitchen.

Adequate ranges and ovens make it possible for kitchen employes to work safely. In one institution where facilities are not equal to the daily task of preparing meals for patients, staff and employes, it is the custom of the chef to grill chops and small steaks on top of the coal range. The range is old and some of the lids and plates are buckled. Miraculously, no fire yet has occurred as the result of fat dripping down upon the coals. Here is one spot where a wise chef would want fire extinguishers handy.

Obviously, flammable liquids should be kept out of the kitchen. There are records of several fires that were caused when floor wax, rubbing alcohol and medicinal oils were being heated on kitchen ranges.

The National Fire Protection Association made a careful study of hospital fires and their causes several years ago. In 73 fires that started in the service department, 14, or approximately 20 per cent of them, had their origins in the kitchen.

FOOD FOR THOUGHT

Tray Appointments

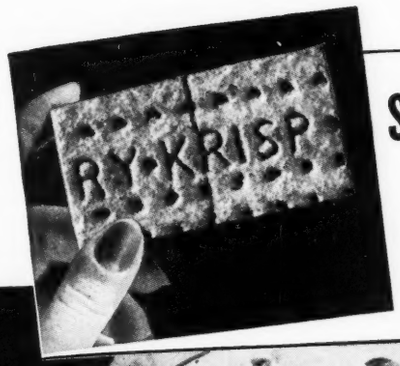
• Too often one hears hospital people criticize the "institutional" look of hospital trays and then in the next breath they assert that, because of initial expense, much handling and careless employes, an institutional type of tray service must be used.

At St. Joseph's Hospital, Kansas City, Mo., according to Mary Merle Buckles, the Sisters have proved that lovely china, glassware, linens and silver are sources of great satisfaction to the patients and of favorable publicity for the hospital. The china is Wedgewood, Lenox, Haviland and hand painted Bavarian; the glassware is cut glass and crystal, etched with colors; the silver service is in matched sets, and linens are handmade in cut work, Madeira and mosaic embroidery.

Every private room has its own tray service, although if a patient's stay is prolonged, the tray service is alternated to prevent monotony. Sometimes a tray is set up entirely with crystalware and, again, an all silver service is used for variation.

These beautiful appointments that have been accumulated over a period of twenty years are in use every day, and not just on special occasions. Each service is washed separately by well-trained maids and any loss is reported at once. As a result of careful supervision, loss and breakage are so small that the cost of replacement is extremely low.

The many complimentary remarks made by patients, both during their stay and afterward, prove that a really attractive tray makes a lasting impression on guests. It also gives one a feeling that dainty trays are possible and that they are not just a utopian daydream.



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October Dinner Menus for the Small Hospital

Jane E. Smith

Dietitian, Chicago Memorial Hospital, Chicago

Day	Soup or Appetizer	Meat, Fish or Substitute	Potatoes or Substitute	Vegetable	Salad or Relish	Dessert
1.	Beef Broth	Meat Loaf, Spiced Crabapples	Mashed Potatoes	Asparagus	Mixed Green Salad	Apricot Sauce, Oatmeal Cookies
2.	Vegetable Soup	Chinese Chop Suey	Buttered Rice	Assorted Chinese Vegetables	Mixed Fresh Fruit Salad	Spice Cake, Mocha Frosting
3.	Fish and Cheese Hors D'oeuvres	Baked Trout	Creamed Pimiento Potatoes	Buttered Squash	Apricot Salad	Apple Brown Betty, Hard Sauce
4.	Okra Soup	Pot Roast of Beef	Hominy Grits	Escalloped Tomatoes	Apple and Cheese Salad	Pumpkin Tarts
5.	Beef Broth	Grilled Lamb Chops, Sausage, Pineapple	Baked Sweet Potatoes	Fresh Green Beans	Celery, Olives	Butterscotch Sundae
6.	Vegetable Soup	Paprika Schnitzel, Sour Cream Gravy	Mashed Potatoes	Buttered Cauliflower	Lettuce With Mayonnaise	Chocolate Frosted Cup Cakes
7.	Broth	Broiled Sirloin Steak	Lyonnaise Potatoes	Harvard Beets	Greens With Roquefort Dressing	Tapioca Cream Pudding, Apricot Sauce
8.	Noodle Soup	Lamb Stew With Vegetables	Mashed Potatoes	Cornbread	Pineapple Salad	Gelatine With Cream
9.	Oxtail Soup	Sautéed Liver	Baked Potatoes	Buttered Lima Beans	Molded Gingerale Fruit Salad	Lemon Tarts
10.	Spiced Fruit Juice	Baked Cod, Cheese Sauce	Potato Balls	Broccoli	Waldorf Salad	Poppy Seed Cake
11.	Cream of Pea Soup	Roast Veal, Spiced Grapes	Escalloped Potatoes	Carrots and Peas	Tomato Aspic Salad	Dutch Apple Cake, Lemon Sauce
12.	Gumbo Soup	Fried Chicken	Mashed Potatoes	Baked Squash	Raw Vegetables, Julienne	Tutti-Frutti Ice Cream
13.	Duchess Soup	Broiled Lamb Chops, Pineapple-Mint Jelly	Potato Balls	Frosted Peas	Lettuce, Thousand Island Dressing	Baked Apples
14.	Barley Broth	Beef Meat Loaf, Spiced Plums	Baked Potatoes	Asparagus	Sliced Beet Salad	Fruit Tapioca With Cream
15.	Scotch Broth, A, B, C Noodles	Swiss Steak	Mashed Potatoes	Succotash	Molded Cabbage and Pineapple in Lemon Gelatin	Lady Baltimore Cake
16.	Mulligatawny Soup	Veal Chops	Baked Potatoes	Glazed Carrots	Tomato Salad	Pineapple Ice Cream, Cookies.
17.	Broth	Fresh Salmon Steaks	Mashed Potatoes	Breaded Cauliflower	Peach Salad	Unbaked Cheese Pie
18.	Vegetable Soup	Salisbury Steak	Escalloped Potatoes	Buttered Greens	Vegetable Aspic Salad	Frozen Plum Pie
19.	Beef Broth, Chopped Parsley	Roast Ribs of Beef, au Jus	Browned Potatoes	Fresh Green Beans	Celery Hearts, Ripe and Green Olives	Peanut Brittle Ice Cream
20.	Fruit Juice Cocktail	Baked Liver With Bacon	Mashed Potatoes	Baked Acorn Squash	Lettuce, Russian Dressing	Apple Dumpling
21.	Broth	Glazed Ham Loaf	Baked Potatoes	Buttered Beets	Orange and Date Salad	Pineapple Tapioca
22.	Noodle Soup	Boiled Tongue, Tomato Sauce	Au Gratin Potatoes	Broccoli	Cabbage and Apple Salad	Orange Cake
23.	Tomato Bouillon	Roast Lamb, Mint Sauce	Mashed Potatoes	Frozen Spinach	Tomato Salad	Cottage Pudding, Blueberry Sauce
24.	Vegetable Soup	Broiled Whitefish With Lemon	Baked Potatoes	Escalloped Corn	Lettuce, French Dressing	Apple Pie, Cheese
25.	Beef Broth	Beef Pot Roast With Carrots and Onions	Browned Potatoes		Pear and Cream Cheese Salad	Pineapple Upside-Down Cake
26.	Chicken Soup	Baked Ham, Cranberries	Baked Sweet Potatoes	Buttered Cauliflower	Celery Curls, Carrot Strips	Orange Ice
27.	Broth, Chopped Parsley	Breaded Veal Cutlets	Diced Buttered Potatoes	French String Beans	Sliced Orange Salad	Loganberry Roll
28.	Broth	Chicken Shortcake		Peas	Peach Salad	Fresh Fruit Cup, Chocolate Covered Graham Crackers
29.	Cream of Tomato Soup	Cabbage Roulette	Baked Potatoes	Spinach	Cinnamon Apple Salad	Lazy Daisy Cake
30.	Beef Broth	Lamb Pie, Potato Crust	Carrots, Onions and Peas	Poppy Seed Rolls	Grapefruit and Pomegranite Salad	Date Bars
31.	Sweet Cider	Vegetable Plate: Julienne Carrots, Fried Eggplant, Spinach, Baked Sweet Potatoes		Hot Biscuits	Cottage Cheese and Chives Salad	Pumpkin Pie With Whipped Cream

Recipes will be supplied on request by The MODERN HOSPITAL, Chicago.

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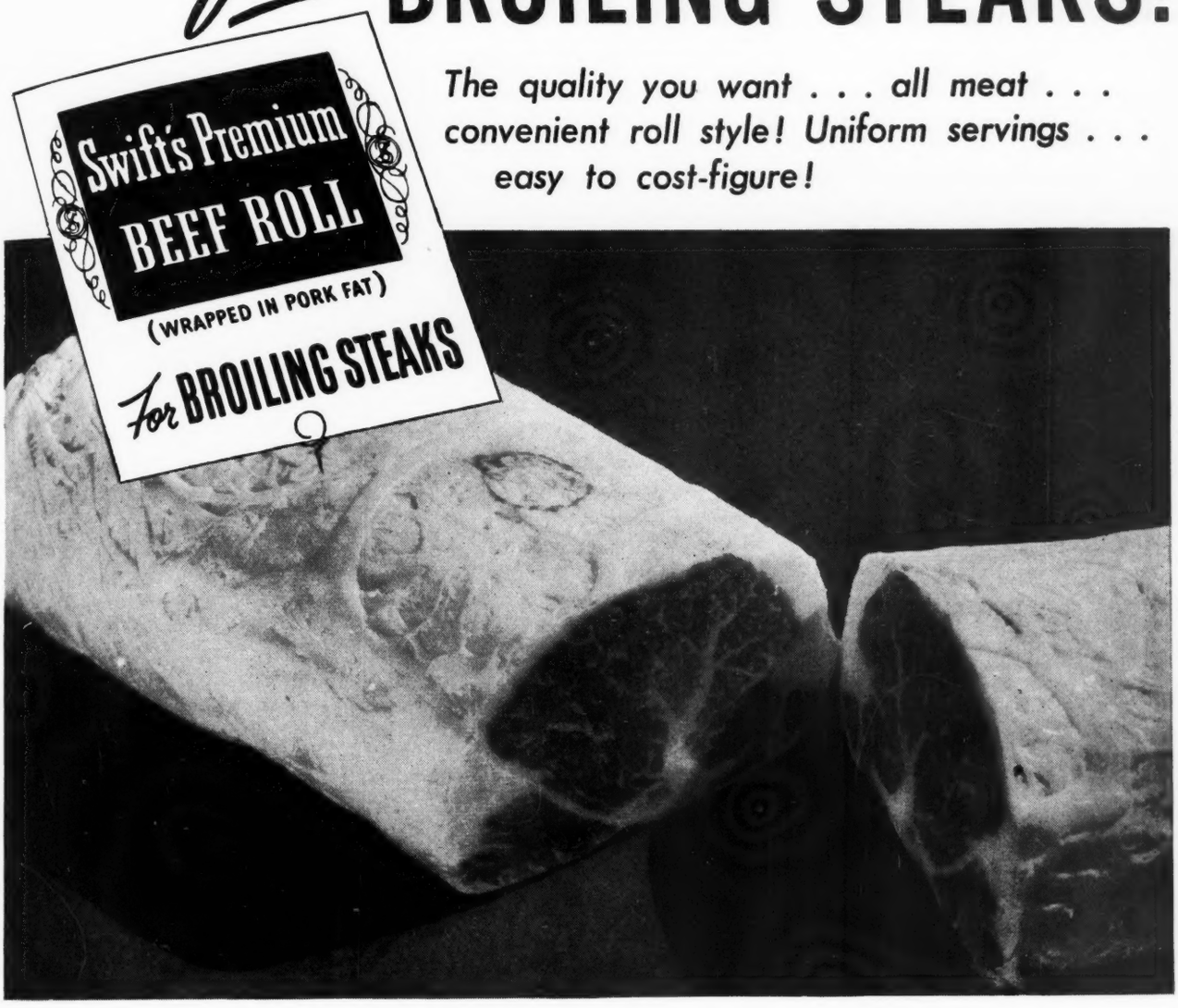

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CHICAGO

Checking Laundry Costs

JACK G. CHARLE
Beth-El Hospital, Brooklyn, N. Y.

FEW of our small or medium sized hospitals that have their own laundry plant are using a cost accounting system worthy of that name. Beyond keeping a record of the number of pounds or pieces laundered during a certain period, no efforts have been made to account for the distribution of laundry costs.

The hospital's laundry represents a considerable investment; its upkeep and pay roll play an important part in the hospital budget. To operate efficiently, the laundry must be able to check its operating costs. Without a system of cost accounting, however simple, control and supervision are impossible. Yet, how many hospital superintendents ask for and receive a monthly cost accounting report from their managers and foremen?

The basis of any system is the determination of the amount of work produced. To accomplish this, it is necessary to keep a record of every piece of linen that is washed and handled by all departments of the laundry.

In Beth-El Hospital, Brooklyn, N. Y., every piece of linen that enters and leaves the laundry is recorded in a special ledger. Every page of this ledger presents a complete daily and monthly picture of the linen requirements of each floor or ward. In this manner the amount of flatwork and finish work used on every floor can be established and easily totaled to show the daily production for the hospital.

The production departments of our laundry have been divided into (1) washing and extracting, (2) flatwork, (3) finish work and (4) rough-dry work. Having an itemized record of every type of linen used, we can allocate its cost to the proper department at the end of the month.

The monthly breakdown of costs presents the following items: pay roll, supplies, power, steam, maintenance, repairs, depreciation, labor insurance and machinery insurance.

Some of these items may be left out or others may be added according to individual needs. It should not be too difficult to arrive at the proper amount for each of them.

For instance, "pay roll" means the total amount of wages paid to all laundry employes; "supplies" is the total cost of all washroom supplies used during the month; "power" is the cost of electricity used in running the machines.

Not all hospitals possess adequate meters to measure the cost of electricity. We have solved that problem by basing electric cost on the total horsepower of all machines. Inasmuch as 1 h.p. equals 0.746 kw., the total horsepower times 0.746 kw. times the total hours of production equals the amount of kilowatt-hours. In such estimates the load factor should not be forgotten. This factor is generally accepted as 70 per cent of the total. The amount to be charged per kw.-hr. has to be based on the estimate of the engineering department.

In a like manner the cost of laundry steam can be estimated. Laundry machines are rated in boiler horsepower and, as 1 boiler h.p. equals the evaporation of 34.5 pounds of water, the steam consumption, when meters are lacking, can be ascertained by the following formula: the rated horsepower times 34.5 times the hours spent in operation.

"Maintenance" is the charge for maintenance of equipment and usually is estimated at about 3 per cent of the total investment. Under "repairs" are placed those items that cannot be handled by the engineering department and, therefore, must be taken care of outside the hospital.

Depreciation charges of the total investment must be left to the discretion of the hospital authorities. These charges will generally range between 5 and 7½ per cent of the investment. "Labor insurance" is insurance paid by the hospital for workmen's compensation. "Machinery insurance" is self-explanatory; most hospitals insure their laundry equipment.

The average cost per piece can be ascertained by dividing the total cost for each department by the number of pieces these departments produced. As an alternative, it is also possible to prorate the total washing and extracting cost between the finished flat and tumbler work to achieve the total cost. The monthly statement, therefore, would appear as on the table below.

This statement presents to the administrator a clear picture of actual costs dependent upon the operation of the laundry.

The way to further analysis is now open. As pointed out previously, we possess in our laundry ledger a daily record of all pieces of linen laundered and distributed. The per piece or per pound cost has been established by the cost report. Therefore, a picture of linen distribution, as

Laundry Costs

	Total	*Washing and Extracting*	*Flatwork*	*Finish Work*	*Rough-Dry*
Pay roll	$	$	$	$	$
Supplies					
Power					
Steam					
Maintenance					
Repairs					
Depreciation					
Labor Insurance					
Total					
Average per Piece					
Poundage					

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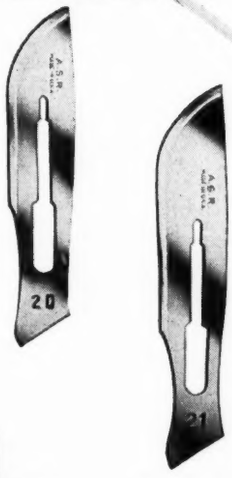

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well as distribution of cost of linen can be presented.

To simplify statements showing distribution, the hospital can be divided into two or three parts as receiving linen. These are:

1. Patients, *i.e.* linen used for the patient directly or indirectly.
2. Employes, *i.e.* employes' uniforms, personal linens and bed linens used in dormitories.

or

1. Patients direct, *i.e.* linens used for the patients' beds or persons while on assigned floors or in rooms.
2. Patients indirect, *i.e.* linens used in operating rooms, laboratories, clinics.
3. Employes, *i.e.* employes' uniforms, personal and room linens.

These statements would then appear as illustrated in the tables shown below.

The advantages and benefits to be derived from a cost accounting system are well worth the time and effort spent on its establishment in the laundry department.

It provides an index for the control of all phases of production and a convenient means of spotting any flaws in it. Upon such an accessible picture of the production departments of the laundry and its operative costs can be based any request for additional or replacement equipment.

The administration will find that such a system will answer all questions regarding the laundry, its problems, its need and its progress.

Distribution of Linen

	Total	*Patients Direct*	*Patients Indirect*	*Employes*
Flatwork	_____ Pieces	_____ Pieces	_____ Pieces	_____ Pieces
Finished Work	_____ Pieces	_____ Pieces	_____ Pieces	_____ Pieces
Rough-Dry	_____ Pieces	_____ Pieces	_____ Pieces	_____ Pieces
Washing and Extracting	_____ Pieces	_____ Pieces	_____ Pieces	_____ Pieces

Distribution of Linen Costs

	Total	*Patients Direct*	*Patients Indirect*	*Employes*
Flatwork	$____	$____	$____	$____
Finished Work	____	____	____	____
Rough-Dry	____	____	____	____
Washing and Extracting	____	____	____	____

With Patients' Welfare in View

MARY BLOUNT ANDERSON

Household Supervisor
Provident Hospital and Training School, Chicago

FROM the executive housekeeper's point of view, the patient is to the hospital what the center is to a circle. Everything she plans in the line of duty revolves around the comfort and welfare of the patient.

Some knowledge of the usual policies and problems of hospitals in general and of her own hospital in particular enables the housekeeper to function intelligently and effectively. Therefore, through study and lectures and current literature she endeavors to keep informed on the demands made upon the executive housekeeper and on the best methods of meeting these demands. By so doing, she approaches her duties with greater patience and broader tolerance toward all concerned; she is better able to undertake the manifold responsibilities that arise through the day, to meet them with quiet assurance and to contribute to the tranquillity to which the patient is justly entitled.

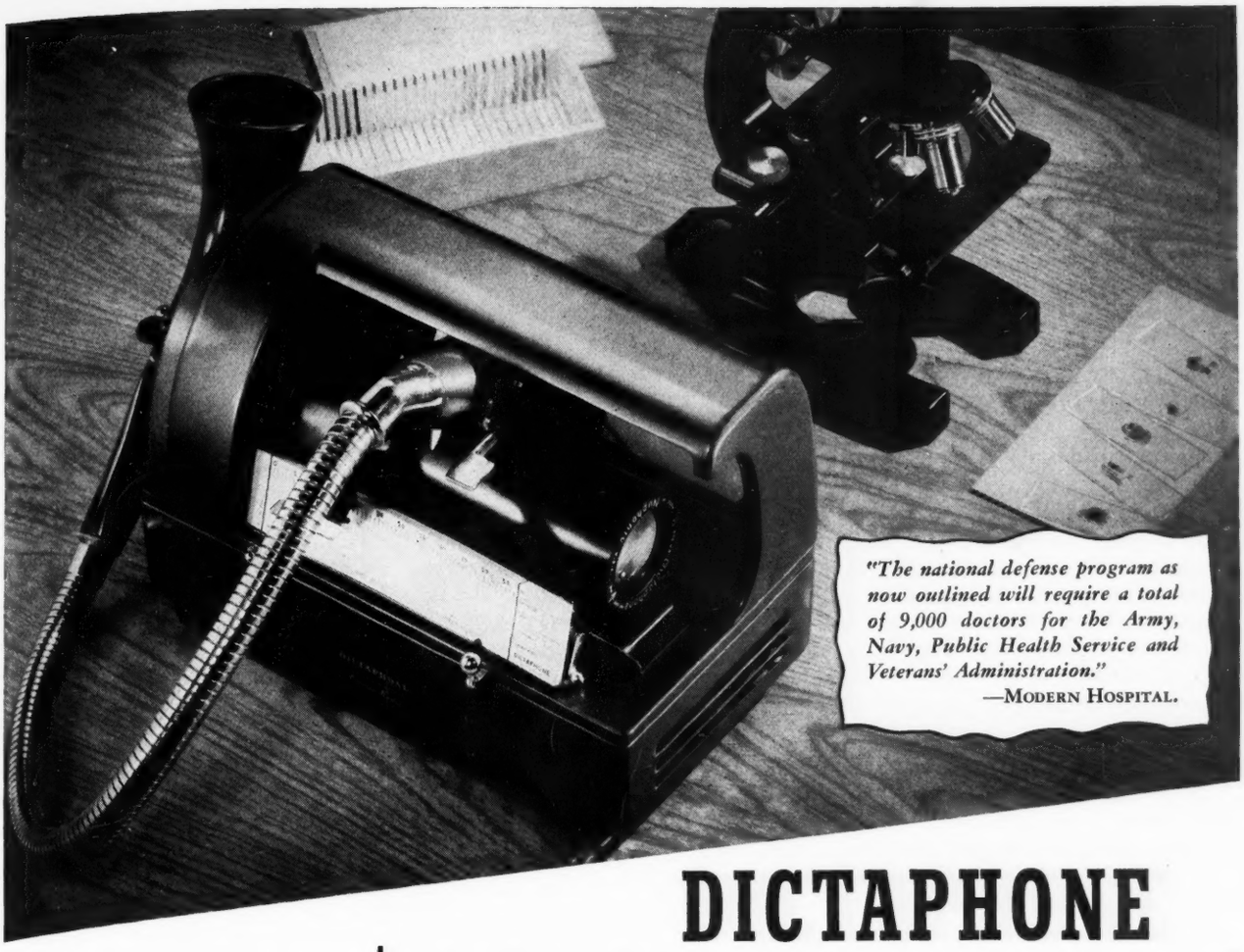
Learning something of the pattern of living in the community the hospital serves is an important phase of the housekeeper's background because she must make plans to meet the particular needs both of the community and of the hospital. In doing this, she is better able to train the personnel of her department to interpret her aims and standards of service as it relates to patient welfare in all respects, from the courtesy of opening a door to the effort involved in cleaning the operating rooms. A determination to cooperate effectively with the heads of other departments is an important factor in the thinking of the executive housekeeper. She must cultivate a wholesome attitude and keep it constant. If the executive housekeeper can make her department feel that it stands squarely back of the nursing department in the care of the patients, she will find the daily course of housekeeping duties running smoothly and adjustments easily made when necessary. She recognizes the importance of regularity in detailed duties as they relate to the attending physician and tries to have these duties satisfactorily completed so that at least he is not disturbed by delay or by the lack of necessary preparedness from the housekeeping angle.

Planning is the paramount consideration in approaching the responsibility of this department. Housekeeping schedules must be so planned that at all hours of the day and night there is an employe of this department on duty in some division of the hospital who can be reached by the house telephone in case of emergency. Moreover, the housekeeper should plan her schedules so that as far as is possible the worker does not disturb patients or hinder those engaged in their care.

In the vocabulary of the executive housekeeper "miscellaneous" is an important word. It often means any minor happening in the hospital that requires immediate attention or adjustment: a sudden rain storm with water here and there; a stray mouse in forbidden territory; an inquisitive cockroach to be dealt with; a collection of magazines to be fumigated, assorted and distributed, or a gift of flowers to be arranged and sent to the wards.

Employes for the department must be chosen with care and trained diligently to fulfill the duties assigned them. They should be drilled in the importance of quietness, courtesy and "smooth service" in every phase of their activity.

With schedules made, with personnel selected and trained and with every possible effort made to keep the hospital clean, attractive and hospitable twenty-four hours every day, the executive housekeeper has caught the spirit of her relation to the patients' welfare.



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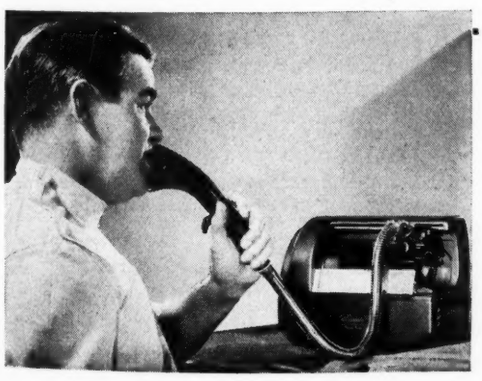

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You, Too, Can Do Research

L. W. BUSSE
Instructor, School of Pharmacy
University of Wisconsin

THE subject of research in the hospital pharmacy can probably be best discussed under three headings: (1) research as an essential or integral part of the hospital pharmacy program; (2) opportunities for research in the hospital pharmacy; (3) problems requiring investigation.

Research, I believe, is essential in the hospital pharmacy for three reasons. The first, and probably the most important, is best expressed by the phrase "research is the enemy of complacency." Its value to a profession has been admirably summed up in the work of Sainte-Beuve: "To lend freshness to things known; to spread knowledge of things new."

A pharmacist cannot keep alive his own interests in pharmacy or the interest of the related professions by remaining within the limits of an established body of knowledge. Established facts in any profession, no matter how important, lose their power to excite; their repetition becomes dull to members and nonmembers alike.

Vitality Measured by Research

The second justification for research was forcibly expressed in a brief report, "Toward an Understanding of the Graduate School," issued by the graduate school of the University of Wisconsin. It states, "The vitality of a graduate school is directly measurable in terms of its research program. This is because the central conception of a graduate school is one in which the faculty members are not merely instructors of known facts but are scholars who work and study on the frontiers of their fields of knowledge."

The same statements may be applied to the profession of pharmacy, especially as practiced in the modern hospital: the vitality of the pharmacy and the pharmacist in the hospital is directly measurable in terms of its research program. Hospital pharmacy and hospital pharmacists cannot progress beyond their present state or bounds merely by using and applying known facts, no matter how important they may be, but must carry out a definite research program in some field, thereby contributing something of value to pharmacy and medicine alike.

The third essential reason for carrying out an extensive research program in the hospital pharmacy lies in the practical value of the research results. Research as an activity stands high in both the esteem of the public and that of the related professions. A new method of administering a drug may bring added health and comfort to thousands. The preparation of stable solutions of drugs which heretofore were not available in such form contributes immensely to the usefulness of those drugs. The discovery of new and more efficient antiseptics and germicides that can be prepared in the hospital will contribute immensely to the field of surgery and obstetrics and will reduce considerably the cost of medication both to the hospital and to the patient. Only when hospital pharmacists contribute something that has added usefulness and value to pharmacy and medicine alike can they take pride in their profession or, probably more important, can the profession take pride in them.

Opportunities for research in the hospital pharmacy are numerous because of the close relationship of the pharmacy to all of the other departments of the hospital. The pharmacy is the center from which all other departments must receive their drugs and supplies; therefore, the hospital pharmacist must of necessity be acquainted with the needs and wants of the other departments in the hospital. The pharmacy may be pictured as the center or "hub" of the wheel and the related departments, the spokes that radiate from the hub.

Because of this close relationship with other departments, opportunities for cooperative research problems are numerous. For example, problems of a strictly pharmaceutic nature could certainly be carried out in cooperation with the department of medicine regarding new vehicles that would make medication more palatable.

Research on the preservation and storage of drugs and solutions with a view of enhancing their permanence and potency would be a valuable contribution.

Tie-in With Dermatology

Often, cooperation with the dermatologist will present many research opportunities of a pharmaceutic nature, such as the administration of drugs in the newer type of ointment bases, the effect of water on the efficiency of the drug in question, the use of the new vinyl resins as bases for the cutaneous application of drugs and the effects of antiseptics when applied in lotion form instead of the much used greasy type of base. Research in these fields is still in the infancy stage and the opportunities for valuable contributions to the professions are numerous.

The possibilities of cooperative research problems with the surgical and obstetrical departments are, likewise, numerous. The ideal antiseptic or germicide for use in sterilizing instruments by no means has been found. Likewise, the ideal antiseptic for use in obstetrics has not been found, when one considers the conflicting opinions as to the relative values of the various antiseptics. A definite research program in these fields carried out by the hospital pharmacist in cooperation with these departments would prove invaluable to the professions and patients alike.

The challenge offered by the hospital pharmacists' slogan, "They must upward and onward who would keep abreast the pace" (Lowell), is one that I hope every member will accept.

Internships in Pharmacy

MEYER J. GILL

Superintendent, Beth Abraham Home for Incurables, The Bronx, New York City

PRIOR to 1934, it was not necessary for New Jersey hospital pharmacies to operate under a state pharmacy permit. There were also many hospitals until that time that did not employ registered pharmacists. However, in 1934 a law was passed whereby all hospital pharmacies must be registered with the New Jersey State Board of Pharmacy and must operate under a permit issued by it. In order to obtain this permit, the hospital pharmacy must fulfill the requirements set by the board. These requirements are practically identical with those that are exacted of a drugstore.

Since that time, a large percentage of class A hospitals, having registered pharmacists in charge, has become registered under the new law, thus elevating the standard of hospital pharmacies. This permits registered pharmacists in hospitals to accept pharmacy graduates as interns, permitting only one intern to work under one registered pharmacist. Official internship is recognized by the state board after graduation. Upon making application for his registration permit, after successfully passing the first half of the state board examination, which pertains to theory, the candidate must serve one year of internship in a drugstore, or its equivalent of six months in a drugstore and six months in a registered hospital pharmacy, before he can take the second half of the examination.

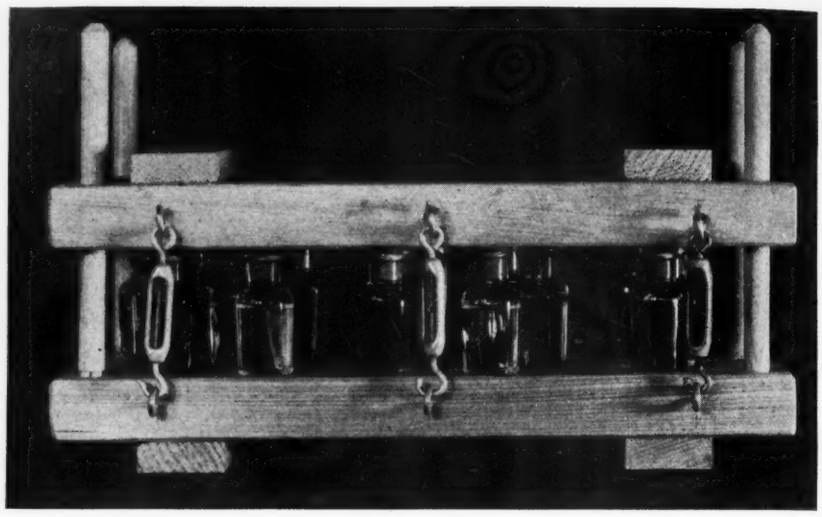
In many cases students entering the college of pharmacy have little or no conception of the practice of pharmacy and have not decided upon the branch in which they plan to specialize. As the student progresses in his studies, various factors and events help him decide in which field he would like to specialize, *i.e.* manufacturing pharmacy, retail pharmacy, teaching or hospital pharmacy.

The establishment of internships in hospital pharmacies for graduate pharmacists is developing all over the country and particularly in New Jersey. Many hospitals are requesting these interns. The hospital pharmacy displays the highest type of professional practice; therefore, it should be used as a part-time training school for these interns. For the same reason, some institutions are accepting college students for a few hours a week. While at the hospital these interns and students come in contact with routine preparations of injectable medications and their sterilization, routine manufacture of pharmaceuticals, the dispensing of drugs, chemicals and pharmaceuticals, the filling and labeling of all drug containers issued to nursing units from which medications are to be administered, the antidotes in emergency rooms, the method of purchasing drugs, chemicals and pharmaceutical preparations, the purchasing and storing of biologicals, and bookkeeping (which includes a perpetual inventory).

In Sterilizing Parenteral Solutions

MORRIS KANTOR

Pharmacist, State Hospital, Poughkeepsie, N. Y.



RUBBER stoppers on vials of parenteral solutions, when subjected to sterilization in dressing sterilizers without due consideration for the effects of ebullition that takes place in the cooling process almost invariably are blown off, subjecting the solution to contamination. It is not uncommon for those engaged in the sterilization of rubber stoppered vials to sustain a loss of 50 or 60 per cent from this cause.

Since rubber stoppered vials of such solutions are advisable, attempts were made to tie down stoppers during sterilization in the hope of counteracting the expansion. Such practice, however, led to violent rupture. Attempts to needle rubber stoppers ended when it was found that the stoppers emerged with a fine needle gash that remained a source of contamination to the solution. Cotton stoppers are also unsatisfactory.

To meet this problem, I devised the apparatus pictured herewith. It is easily constructed and durable. Built of cypress wood, it will withstand appreciable warping.

The vials of solutions to be sterilized are placed on the lower board of the adapter, properly spaced. The upper board, lined with a sheet of tinfoil, fits evenly through four wooden pegs on top the lower board. When the upper board is brought down to the required height, it is fastened securely by three turnbuckles on each side of the boards. The adjusted apparatus with vials securely in place is then placed inside the dressing sterilizer. Various solutions, varying in strength, may be sterilized in one operation.

NOTES AND ABSTRACTS

Conducted by Carl C. Pfeiffer, M.D., F. F. Yonkman, M.D.
Arnold J. Lehman, M.D., and Harold Chase, M.D.

Drugs and Motion Sickness

Motion sickness is a collapse of the autonomic nervous system and is considered as a normal response to an abnormal environment. The continual and rapid changes in position that are experienced while riding in a bouncing airplane, a rolling boat, or a swaying automobile stimulate repeatedly the nerves that control the balancing mechanisms. If the motion stimulus is maintained long enough, nervous exhaustion is almost certain to occur with attending signs and symptoms of air, car or seasickness. It has been reliably estimated that, under appropriate conditions as to range, character and duration of movement, probably less than 5 per cent of individuals would not develop motion sickness.

A great many remedial and prophylactic measures have been tried in the management of the distressing symptoms but in order to put a true valuation on the usefulness of such agents some facts concerning the physiologic basis of motion sickness should be considered.

Physiologic Basis

• A normal individual balances himself by sensations originating from three sources. First, the inner ear with its saccule and utricle conveys sensations of vertical movement. The semicircular canals transmit changes in angular movements. Sensory impulses travel over the vestibular nerve and stimulation to a point beyond normal tolerance may reflexly involve the vagus.

A second series of motion stimuli originates from muscles, especially those of the leg, back and neck. Swaying movements create a continual sensation of push and pull by shifting of body weight to one leg or the other. The multiplicity of these somatic impulses results in some unusual responses from the autonomic nerves as the body attempts to localize itself in space. Eyestrain and fatigue of eyeball muscles offer a third source of irritation. In a lurching boat, man attempts to orient himself with relation to the earth by observing positions of stationary objects. Prolonged visual stimuli of this nature can provoke seasickness. According to some experimental work carried out in Germany, tugs and pulls on abdominal viscera, especially in the region involving the celiac plexus, may also produce evidence of an unstable nervous system.

Outstanding Characteristics of Motion Sickness

Symptoms	*Vagotonia*	*Sympatheticotonia*
Nausea	Variable	Constant
Vomiting	Absent or only at long intervals	Frequent and repeated
Relief of nausea after vomiting	Usually marked	Slight or transient
Headache	Early, persistent, often occipital or vertical	Frontal, if present at all
Vertigo	Early	Late
Pulse rate	60 or less	80 or more
Blood pressure	Low	May be above normal

Types

• Excessive sensory impulses from these three or four sources tend to upset nervous coordination. If the vagus nerve appears to be overactive, a type of syndrome called vagotonia is produced. "Sympatheticotonia" is the term applied to symptoms predominantly of sympathetic origin. Combinations of the two types can obtain in an almost endless variety. Excitation competes with inhibition; responses of the individual depend upon which obtains the upper hand in this conflict.

A brief summary of the outstanding characteristics of motion sickness will assist in determining which division of the autonomic system shows greatest involvement.

Drugs

• Many drugs have been suggested as effective in treatment. Physiologically, the parasympathetic and sympathetic systems are mutually antagonistic. In accordance with this it is possible, therefore, to stimulate one system by suppressing its antagonist. Sympathetic depression may be obtained by augmenting the vagus with prostigmine, acetylcholine or pilocarpine. The last named has been successfully tried on this basis in excessive vomiting. On the other hand, atropine can increase sympathetic tone by removing the braking influence of the parasympathetic nerves. Sympathetic inhibition directly is more difficult. Depressants of the central nervous system are usually employed to accomplish this purpose. Barbiturates, chloretone (mothersill), bromides and chloral hydrate have been recommended.

The best of these, according to Hill, consists of sodium bromide, chloral hydrate and tincture of belladonna. Pharmacologically, bromide acts on the cortex of the brain and slows down reflex activity. Chloral hydrate depresses activity of the brain stem, thereby obstructing extraneous impulses, and belladonna (atropine) releases vagotonia.

Recommended Dosages

Drug	*Vagotonia Predominant*	*Sympatheticotonia Predominant*	*Intermediate*
Tincture of Belladonna	1.0 cc.	0.3 cc.	0.6 cc.
Sodium Bromide	2.6 gm.	5.2 gm.	4.0 gm.
Chloral Hydrate	1.0 gm.	1.6 gm.	1.3 gm.

The ingredients are mixed with sufficient water to make 30 cc. and a teaspoonful is administered every half hour.

A few of the newer barbiturates have achieved some popularity in this field. They are efficient hypnotics but it has been observed that the beneficial effects last only as long as the drug acts. Apparently, this does not hold with the bromide-chloral combination.

Prophylaxis

• Little need be said regarding prophylactic measures. One can adapt himself to an unusual environment by developing a conditioned reflex. This is accomplished by exposure to a gradual increase in strength of stimulus over a period of time. An example of this would be to take short daily trips in a small boat for a few days before boarding a steamer. European investigators have found that considerable immunity to car sickness may be obtained by placing the susceptible individual in a prone position in the vehicle. A tight binder around the abdomen apparently does not prevent visceral tugs.

Generally speaking, the best treatment would be to remove the cause. Since this is not always possible, despite advancement in balancing gyroscopes for ships, stratosphere flying and better highways, a redeeming feature of motion sickness is its relative short duration. On board ship the traveler learns to walk with his feet rather than on them in about three days. Airplane trips are a matter of a few hours. Under these circumstances all recommended measures are probably superfluous. Drugs should be used only as the last resort.—Arnold J. Lehman, M.D.

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FOLESTRIN *Armour* is biologically assayed for potency. It is available in three forms.

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FOLESTRIN *Armour,* a natural, highly purified preparation of estrogenic substances derived from pregnant mares' urine, has a therapeutic indication in each phase of woman's life.

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News in Review

A-10 Priority Rating to Be Granted to 14 Varieties of Hospital Supplies

RUTH HILL ZIMMERMAN
Washington Correspondent, The Modern Hospital

A health supplies rating plan including initially 14 categories of health supplies was on the point of being set up in the Office of Production Management as this issue of The MODERN HOSPITAL went to press. The plan was developed with the active cooperation of the Army and Navy Medical Corps.

If the plan is approved, manufacturers of these supplies will be able to secure an A-10 preference rating to facilitate obtaining necessary materials.

Milton Luce, who, it is anticipated, will be in charge of the administration of the plan, will be assisted by a semi-official board, already appointed. This board, according to Mr. Luce, is composed of representatives from interested agencies with primary emphasis on representing users of health supplies.

The board has already agreed to include under the plan the following types of health supplies: adhesive plasters, anesthesia apparatus and supplies, biologicals, antitoxins, serums, clinical thermometers, diagnostic instruments, laboratory equipment, laboratory supplies, operating room equipment, hypodermic syringes and needles, instruments (surgical and dental), medicinal chemicals (limited to medical use only), rubber sundries, sterilizers, surgical dressings, x-ray equipment and supplies (medical and dental). Undoubtedly, the board will add other items to this list.

Hospital administrators will not need to establish priority under the plan, but manufacturers who supply hospitals and other health agencies are expected to communicate with the health supplies rating plan, Office of Production Management, requesting application forms and furnishing lists, not catalogs, of articles manufactured, arranging them according to scarcity. The preference rating, A-10, will be issued to manufacturers who qualify themselves in this manner and will remain in effect until recalled. It may be passed from source to supply source and back, if necessary, to the source of raw materials.

Apportionment of scarce materials for the current three months' period will be based on reports of the materials used during the previous three months. When increased quantities are asked, full explanation will be required. At the end of each period the manufacturers will be required to account for the materials used and to report needs for the next months. These reports are to be analyzed carefully by the Office of Production Management, which has announced that it will not permit use of scarce materials to increase stocks.

The Division of Priorities of the Office of Production Management has also been working on a maintenance and repairs rating plan, which, it is anticipated, will assure hospitals and other essential industries of a steady flow of parts needed for their satisfactory operation. Up to the time of publication of this issue, however, the order affecting hospitals had not been promulgated.

It was understood that orders issued under the new rating plan will implement the priority preference program announced by the Civilian Supply Allocation Division of the Office of Price Administration and Civilian Supply (O.P.A.C.S.) on June 30.

The Office of Production Management, it is reported, has divided the 26 industries to be benefited into several groups. Hospitals, clinics and sanatoriums are included in the second group.

E. R. Stettinius Jr., director of priorities, announced details of the maintenance and repairs rating plan, covering the first group of these industries on August 8 but later the notice was withdrawn, apparently because administrative facilities of the O.P.M. were not yet sufficiently well organized to take care of the flood of applications expected.

The recalled plan provided for an A-10 rating under ordinary circumstances and an emergency rating of A-1-a. The latter would be available on telegraphic application in case of such catastrophes as fire, flood, explosion or major breakdown.

Pneumonia Film Released

A new ten minute motion picture on pneumonia, "A New Day," is now available from the Metropolitan Life Insurance Company. The film is sponsored jointly by the company and the U. S. Public Health Service and is being shown in some commercial theaters. It is also available for loan to health agencies and comes in either 16 or 35 mm. width for a sound motion picture machine.

M. BURNEICE LARSON, DIRECTOR

At a time when Opportunity seemingly knocks not *once*—but every few days—it becomes increasingly evident that it is not always Opportunity who does the knocking! It also becomes increasingly important to recognize Opportunity when she *is* standing on the threshold.

It is important to every member of the medical profession—to every individual in the hospital household . . . the administrator, the nursing staff, the staff of technicians, the dietitians, the business corps . . . to make each professional move an advantageous one. It is essential to *know* that in leaving one appointment, one is making genuine professional progress.

Our files are bulging with material concerning hospitals, clinic groups, "names" in the medical profession and in hospital administration. We can counsel you in your efforts to recognize Opportunity and avoid making a decision to be regretted within a few weeks or months.

If you are ready to undertake greater responsibility and if a nation-wide survey of present openings in your field would be of assistance, write for one of our registration forms today. Your correspondence with us will be kept in complete confidence. We believe you will find our service helpful in influencing a wise decision.

The MEDICAL BUREAU

PALMOLIVE BUILDING **CHICAGO**

Civilian Hospital Construction May Be Concentrated in Defense Areas

RUTH HILL ZIMMERMAN
Washington Correspondent, The Modern Hospital

Construction and expansion of civilian hospitals in defense areas or to meet specific defense needs may be practically the only hospital construction work possible for the duration of the present emergency.

The difficulty lies, of course, in the impossibility of obtaining essential materials and labor in competition with defense activities which are being given higher priority ratings by the Office of Production Management.

Projects approved under the Community Facilities Act (Public Law 137, approved June 28), which authorizes the expenditure of $150,000,000 of federal funds for the acquisition and equipment of public works made necessary by the defense program, including hospitals, are assured of receiving, more or less automatically, a defense rating high enough to permit them to obtain needed materials.

Other civilian hospital projects are to be considered by the newly formed construction and transportation section of the Civilian Allocation Division of the Office of Price Administration and Civilian Supply (O.P.A.C.S.) where a corps of workers, under direction of John L. Haynes, acting chief of the section, has just begun compilation of estimates, based on past experience, of materials needed for civilian hospital construction.

Depending on apparent need, the efficiency and economy of the proposed plans, availability of materials and similar factors, these projects will be given civilian ratings (such as B-1, the highest) or, in certain cases, will be recommended to the Office of Production Management for defense ratings. Defense ratings, according to an official of the Office of Production Management, will be granted only if the hospital can prove need arising through the fulfillment of some defense function, such as participation in selective service examinations or training of nurses for military or defense service. Even with a defense rating, however, difficulty may be experienced in obtaining materials. For example, it is understood that a large housing project approved and undertaken months ago to provide housing for workers in an important Navy shipyard is still uncompleted owing to the difficulty of obtaining materials, particularly metal equipment, such as water tanks and hardware.

Applications for federal aid in hospital construction, including, of course, expansion of existing hospitals, in extra-military and defense industrial areas, under the act mentioned above, are now being received by the 12 regional offices of the Federal Works Agency. The U. S. Public Health Service is assisting the Federal Works Agency in study of these projects. It has prepared itself, during the past year, by reconnaissance surveys covering 115 critical areas in which it was seen that immigration of population would take place as a result of the presence of military camps or industrial activity concerned with defense.

No definite proportion of the $150,000,000 appropriated has been set aside for hospital construction and no estimate was available by the middle of August as to the amount that would be spent for hospitals except that it was anticipated that the construction and maintenance of schools, water works, sewers and other community facilities included would take the lion's share of the appropriation. Surgeon General Thomas Parran, testifying before the House committee investigating national defense migration on July 18, stated that the Public Health Service surveys indicate a need

(*Continued on page* 128)

Administration Has Not Dropped Health Insurance Aims, Altmeyer Indicates

Intimations that the Social Security Board will continue to press for health insurance were given in testimony by Arthur J. Altmeyer, chairman of the board, in a hearing before the House committee investigating national defense migration on July 18.

"You are well aware that a pattern for health security has been laid out," Mr. Altmeyer told the congressmen. "Last year and this, Congress has had specific bills available for careful study, bills intended to enact sound programs to meet well-defined needs for new hospitals, clinics and sanatoriums, and for funds to encourage their effective use; for strengthened public health, maternal and child health services; for more adequate medical services for all the people, and for protection against disability.

"Some sharp clashes have centered around the proposals for health insurance," he stated. "There are those who say that such proposals lead inevitably to 'socialized medicine,' a vague phrase. 'Socialized medicine' is something to which I am opposed if that phrase means a system that destroys the personal relationship between the patient and his doctor. What we are interested in is the destruction of an even more personal relationship—the personal and exclusive relationship between the patient and his disease. In that we and the doctor have a common aim.

"But this is largely beside the point, because there is no reason why a plan cannot be evolved that will preserve the patient's right to choose his doctor. Indeed, I believe it is possible to develop a plan that will make it possible for a great many patients to exercise that right for the first time. The present trouble about free choice of doctor is that so many people have neither a choice nor a doctor.

"Health problems that demand attention call for increased efforts on two broad fronts: on the one hand, the provision of adequate facilities for the prevention, diagnosis and care of illnesses where these are now insufficient or lacking; and, on the other, means of making it possible for individuals to use such services when they are available.

"We must be able to assure people that they will have a self-respecting income and independence when illness interrupts their ability to earn—to assure them, in plain words, that they can afford to admit they are sick, that they can better afford to stop work than to risk death."

Nursing Recommendations Issued

In order to improve nursing conditions in the community, especially during week ends, the Central Directory for Registered Nurses, St. Louis, has issued a new set of recommendations for private duty nurses. Under the plan, all nurses who have been on the registry for less than five years are subject to call for any one of the three periods; all nurses are asked to take cases in any hospital at which they are needed, and if it is impossible to get enough nurses to fill the calls nurses are expected to special two patients when such a plan is feasible.

Syracuse Campaign Nears Goal

Toward its goal of $500,000, Syracuse General Hospital, Syracuse, N. Y., received $470,000 in a recent fund-raising campaign, according to C. P. Wright, superintendent. Pledges received to date, according to Mr. Wright's report, total 5050, excluding the pledges of the individual members of the Syracuse Teachers' Association whose pledge came as a single gift from the association; 750 persons volunteered their time to work actively in the campaign.

200 Nursing Schools Apply for Federal Aid for Expansion of Basic Training

WASHINGTON, D. C.—Approximately 200 of the 500 schools of nursing that were eligible have applied to the U. S. Public Health Service for aid in expanding their schools to give basic training to more student nurses. Preliminary applications indicate a need for 400 additional instructors, supervisors, and head nurses to carry out these plans.

Late in August Margaret Arnstein and her associates in administrating the new program were examining second application forms in an effort to give approval to as many plans as possible before the opening of the new school year in September. Surgeon General Thomas Parran issued a call on August 15 for 50,000 well-educated young women to begin training for professional nursing careers.

Meantime, consideration of plans for 90 refresher and 40 postgraduate courses was postponed until after approval of the basic courses.

Protests have been received, according to Miss Arnstein, against the regulation limiting federal aid for basic courses to schools that are connected with hospitals having a daily average of at least 100 patients. The Public Health Service recognizes that this rule works a hardship in certain areas in which hospitals are small and the shortage of nurses is acute, but because the total appropriation ($1,250,000) was small relative to the need, it was felt to be more economical to limit grants to the larger institutions. Later, if more money is available, the program may be extended to schools associated with smaller hospitals.

Four-Month-Old West Penn Strike Is Settled; Union Not Recognized

The strike of hospital employes at Western Pennsylvania Hospital, Pittsburgh, was ended on August 12. By far the longest and, perhaps, the bitterest such dispute known to hospitals in recent years, the strike lasted just six days under four months.

In announcing the end of the strike, the hospital stated that it promised to do the following: to raise wages of the service employes to a minimum of $45 per month as soon as sufficient money is available either from an increased state appropriation or increased hospital receipts and to use every effort to obtain an increase in the hospital income; to permit the employes to choose a committee of their own representatives from among the hospital employes, which committee, as employes, shall have the right to meet with the hospital management at all reasonable times; to give the employes' committee the right to appeal from any decision of the hospital management in connection with matters affecting the employes to a committee of the hospital board of directors, which shall appoint a subcommittee to act on such appeals.

The hospital also promised that as vacancies occur among the service employes striking employes shall be rehired by the hospital on application without discrimination, in order of seniority, but no former employe who has participated in acts of violence or who has been convicted of violating the injunction issued by the court of common pleas will be rehired.

The hospital refuses to recognize the union.

The hospital expected to rehire from 20 to 25 of the striking employes within two weeks of the settlement of the strike and, as vacancies occur, to take back about 75 to 100 others before January 1. The hospital stated that it would not reemploy any striker who had been active in promoting the strike.

O.C.D., Hospitals and Red Cross to Train 100,000 Nurses' Aids Annually

In collaboration with the American National Red Cross and the major hospitals of the country, 100,000 volunteer nurses' aids will be trained during the next twelve months. The program is in preparation for a great expansion in hospital beds which may be required during the national emergency, Mayor F. H. La Guardia, U. S. director of civilian defense, announced.

The growing deficiency in hospital personnel is now being met in part through the training of large numbers of paid subsidiary hospital workers by the N.Y.A., W.P.A. and other agencies. The training program for volunteer nurses' aids is designed to expand the effectiveness of the trained nurse in hospitals, clinics and field nursing services by supplying her with intelligent assistants who can work under her direction.

The curriculum of instruction has been prepared by the medical division of the Office of Civilian Defense, the American National Red Cross and the Federal Security Agency. Eligibility is limited to women between the ages of 18 and 50 who have had at least a high school education or its equivalent and who are physically fit. The course will provide eighty hours of intensive instruction in a period of seven weeks.

The first half of the course will be given in the local Red Cross chapter house in collaboration with local hospitals and nursing organizations. This will constitute the probationary period and will require two hours of instruction daily on five days a week for four weeks.

The second half of the course will consist of supervised practice in a hospital that has been designated by the Office of Civilian Defense and the Red Cross as a training center. The American National Red Cross will assist the hospital to provide competent instructors and nursing supervisors.

Those who complete the course will be enrolled in the volunteer nurses' aid corps of the American Red Cross. They will retain their membership in the corps only so long as they continue to render adequate service during the period of national emergency. This is defined as 150 hours of volunteer service in a hospital, clinic or field nursing organization in at least one three month period in each calendar year.

The Office of Civilian Defense and the American National Red Cross will provide for this continuing service by agreement with local hospitals and field nursing agencies. For this purpose, the Red Cross will maintain a placement bureau, which will allocate volunteer nurses' aids to the following types of nursing service: hospitals and clinics, visiting nurse (home visiting) agencies, health departments, school health services and industrial hygiene clinics.

N.Y.A. to Aid Nursing Students as in Four Kentucky Projects

Following the success of an experiment in Kentucky, where, since February, the National Youth Administration has given financial assistance to student nurses in two schools of nursing, the N.Y.A. in Washington has indicated its willingness to cooperate in similar programs in other states. Arrangements will be made depending on state laws and sponsorship of the plans.

A description of the experiment at St. Joseph's Hospital and Good Samaritan Hospital in Lexington, Ky., was published in the August issue of the *American Journal of Nursing*. In September the Louisville City Hospital and SS. Mary and Elizabeth Hospital, also in Louisville, will begin similar programs, which will pay approximately $16 a month to each N.Y.A. student in exchange for about fifty hours of service, preferably at "sit-down" jobs.

Hospital Service Increase in 1940, Reports Chicago Council of Social Agencies

Hospital service in Chicago increased in 1940 considerably over 1939 whereas clinic service decreased, according to a report released last month by the health division of the Council of Social Agencies of Chicago.

The total number of patient days of hospital service in 33 reporting hospitals was 3,424,574 in 1940 as compared with 3,311,795 in 1939. The percentage of free days was 72.3 in 1940 and 73.6 in 1939. These figures, of course, include the services of Cook County Hospital and the other governmental as well as voluntary institutions. Part of the decrease in percentage of free days is attributed by Alexander Ropchan, secretary of the health division, to the increased enrollment in the 67 Blue Cross plans throughout the United States.

There were only 3,020,738 clinic visits in 1940 as against 3,185,208 in 1939, the division reported. This decrease is apparently due primarily to the effect of the vigorous venereal disease campaign that the Chicago board of health has been waging for several years. Whereas a few years ago 7 per cent of persons given blood tests for venereal disease were found to have a positive reaction, this percentage during 1940 dropped to 4. Mr. Ropchan suggests that the drop indicates that a large part of the chronic cases has been found and brought under treatment and that the cases now being cared for are primarily those with infections which have been contracted fairly recently.

In 1940, a total of 1,715,112 out-patient visits was made to governmental clinics, including the new Cook County Clinic housed in the building formerly occupied by the West Side Hospital. This clinic, with approximately 300,000 visits annually, is today by far the largest general out-patient clinic in the city, the division states. A total of 1,305,626 visits was made to the nongovernmental clinics reporting. Two of these, Children's Memorial Hospital and Mount Sinai Hospital, have expanded their clinic facilities appreciably during the last year.

"Hospital beds for Negro adult patients are seriously inadequate," the council stated, but it points out that Michael Reese Hospital and Women's and Children's Hospital have expanded their facilities for caring for Negro patients and that the construction program for Wesley Hospital "for the first time made provision for the care of Negro patients." It is expected that these facilities at Wesley Hospital will be available early in 1942.

Physical Therapy Course Offered Foreign Physicians

As part of the hemispheric defense program of the U. S. Department of State a special course in physical therapy for medical officers of the American republics and Canada will be offered by the school of medicine at Northwestern University, Chicago.

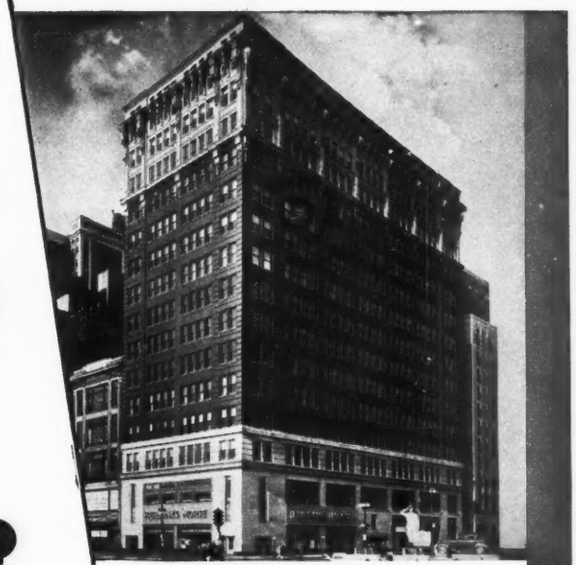
According to Dr. John S. Coulter, head of Northwestern's physical therapy department, the course will begin October 6 and will run three months. It will be conducted by regular faculty members of the school of medicine. All the facilities of the school of medicine will be employed, including the clinics, the physical therapy departments of Passavant and Wesley Memorial hospitals, and the laboratories of the school itself.

It is anticipated that the majority of doctors who will take this specialized course will come from the Latin American nations, Doctor Coulter said.

Methodist Hospital Incorporates

The local property of the Methodist Hospital, Gary, Ind., according to a recent announcement made by the board of directors, has been purchased from the State Association of Methodist Hospitals of Indiana and has been incorporated under the name, The Methodist Hospital of Gary, Inc.

WHAT MAKES BETTER BUILDINGS STEADY USERS OF BARRELED SUNLIGHT?



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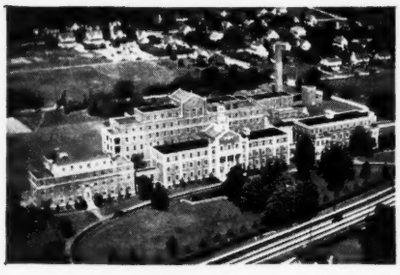

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Homeopathic Hospital, Providence, R. I.
Knickerbocker Hospital, New York City
St. Mary's Hospital, San Francisco, Calif.
Uniontown Hospital, Uniontown, Pa.
University Hospital, Chicago, Ill.

BARRELED SUNLIGHT

Meta Pennock Announces Retirement as Editor; Janet Geister Takes Over

After twenty years of service to the nursing profession, Meta R. Pennock, editor of *Trained Nurse and Hospital Review,* announced her retirement in the August issue of that publication.

In her farewell editorial, Miss Pennock writes: "Immediately the cycle begins to repeat itself—shortage of graduates, more students, more nurses' aids until, if the dragon should suddenly cease his roaring, many states lacking legal control would find themselves trying to sell good and poor nursing in a glutted market. But there are brighter aspects to the situation for 1941. The advent of group plans for the financing of hospital care has resulted in greater stabilization of employment; the national accreditation plan is actually reaching students so that they will not be trapped in nursing schools which have little but good intentions upon which to build a sound nursing foundation. That public health nursing is expanding rapidly to absorb greater numbers of properly prepared nurses will ward off the day of unemployment; that students, in their basic course, are gaining a true perspective of prevention will guarantee their ability to take up the slack."

Janet M. Geister, R.N., who for two years has been coeditor of the magazine, has been appointed editor. Miss Geister is one of the best known figures in the nursing world, having served as executive secretary of the American Nurses' Association for a number of years. She is also known for her writings and for her studies and leadership in the public health and general nursing fields.

Coming Meetings

Sept. 1-5—American Congress of Physical Therapy, Mayflower Hotel, Washington, D. C.
Sept. 1-5—American Occupational Therapy Association, Mayflower Hotel, Washington, D. C.
Sept. 6—San Francisco Ass'n of Medical Record Librarians, San Francisco.
Sept. 11-13—Biological Photographic Association, Hotel Buffalo, Buffalo, N. Y.
Sept. 12-14—American Protestant Hospital Association, Atlantic City, N. J.
Sept. 13-15—American College of Hospital Administrators, Atlantic City, N. J.
Sept. 15-19—American Hospital Association, Atlantic City, N. J.
Oct. 2—Manitoba Hospital Association, Winnipeg, Man.
Oct. 8-10—Ontario Hospital Association, Royal York, Toronto.
Oct. 14-17—American Public Health Association, Hotel Traymore, Atlantic City, N. J.
Oct. 20-23—American Dietetic Association, Hotel Jefferson, St. Louis.
Oct. 20-31—New York Institute for Hospital Administrators, New York City.
Oct. 23-24—Missouri Hospital Association, St. Louis.
Oct. 24—Idaho Hospital Association, St. Joseph's Hospital, Lewiston.
Oct.—Alberta Hospital Association, McDonald Hotel, Edmonton.
Oct.—Saskatchewan Hospital Association, Moose Jaw, Sask.
Oct.—British Columbia Hospital Association, Empress Hotel, Victoria.
Nov. 3-6—Hospital Standardization Conference, American College of Surgeons, Statler and Copley-Plaza hotels, Boston.
Nov. 12-13—Kansas Hospital Association, Topeka.
Nov. 13-14—Oklahoma Hospital Association, Oklahoma City.
Nov. 17-28—Southwestern Institute for Hospital Administrators, Southern Methodist University, Dallas, Tex.
Dec. 4—Utah Hospital Association, Salt Lake City.
Jan. 1942—Wisconsin Hospital Association, Hotel Schroeder, Milwaukee.
Feb. 26-28, 1942—Texas Hospital Association, Houston.
March 11-13, 1942—New England Hospital Assembly, Hotel Statler, Boston.
April 6-10, 1942—American Congress on Obstetrics and Gynecology, St. Louis.
April 13-16, 1942—Association of Western Hospitals. Olympia Hotel, Seattle, Wash.
April 27-29, 1942—Iowa Hospital Association, Fort Des Moines Hotel, Des Moines, Iowa.
June 8-12, 1942—American Medical Association, Atlantic City, N. J.

New Building for Broadlawns

Contracts have been let for a new four story building for Broadlawns General Hospital, Des Moines, Iowa. The new building, a 150 bed hospital with provisions for emergencies and for an outpatient department, has been designed as a flexible hospital unit for the care of indigent patients. The estimated cost for the construction is $614,190.

Service Plan Commission's Report Shows Increase in Blue Cross Enrollment

The 67 approved nonprofit Blue Cross, or hospital service, plans in the United States and Canada had a total enrollment of 7,015,000 on July 1, according to figures compiled by the Hospital Service Plan Commission.

A year earlier the enrollment was 5,180,000, giving a growth of nearly two million subscribers and dependents during the period.

The ten largest plans in the country, with their enrollment, are as follows: New York City (1,270,900), Cleveland (490,900), Michigan (436,200), Minnesota (416,500), Pittsburgh (365,600), Philadelphia (303,100), Massachusetts (298,400), New Jersey (278,000), Chicago (275,000) and Connecticut (217,600).

Several of the plans have grown rapidly during the twelve months ending on July 1. These, with the amount of their increases, are: Michigan (207,000), Cleveland (135,000), Pittsburgh (125,000), Chicago (100,000), Minnesota (74,000), Philadelphia (70,000), New Jersey (63,000), Massachusetts (60,000), St. Louis (60,000), Cincinnati (55,000), Connecticut (52,000), Buffalo (43,000), Toledo (41,000), District of Columbia (35,000), Colorado (33,000), Rhode Island (29,000), Youngstown, Ohio, (28,000), Iowa (24,000), Rochester, N. Y., (24,000), Rockford, Ill., (23,000), Baltimore (23,000) and Akron, Ohio, (22,000).

During the month of June alone the Michigan Hospital Service plan enrolled 101,000 members. This is probably the first time that any of the Blue Cross plans has added 100,000 subscribers in a single month.

Civil Service Supplements Opportunities for Nurses

The need for qualified nurses for governmental service, particularly for public health service in those parts of the country in which large defense industries are located, is increasing with the national defense program.

The civil service examination designated as Public Health Nurse ($2000 a year), which has been open for some time, now has been supplemented with a Junior Public Health Nurse examination ($1800 a year), which requires no experience. Applications also are being received for examinations now open for Junior Graduate Nurse ($1620 a year) and Graduate Nurse for General Staff Duty ($1800 a year).

Foundation Distributes Grants for Further Study of Infantile Paralysis

Among the institutions and organizations to which the National Foundation for Infantile Paralysis has distributed new grants to permit study of treatment to combat the disease are the following:

Hospital of the New York Society for the Relief of the Ruptured and Crippled, New York City, $1000; New York Orthopedic Dispensary and Hospital, New York City, $1750; Hospital for Joint Diseases, New York City, $1750; Children's Hospital, Boston, $6300; Massachusetts General Hospital, Boston, $2500; Boston City Hospital, Boston, $3000; Strong Memorial Hospital, Rochester, N. Y., $9200; University Hospital, Iowa City, Iowa, $7100; Michael Reese Hospital, Chicago, $7930, and Children's Hospital, Baltimore, $400.

Hospital Service Plan Changes Name

The Massachusetts hospital service plan has announced adoption of a new corporate name, Massachusetts Hospital Service, Inc. The new name, the announcement suggests, will relate the organization more closely to the 66 other Blue Cross hospital service plans operating throughout the country.

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Public Health Service Institutes Program for Venereal Disease Control

To minimize the spread or increase in venereal disease that may result from concentration of large sections of the population for military or industrial purposes, a nation-wide program of venereal disease control has been instituted by the Work Projects Administration under the sponsorship of the U. S. Public Health Service.

According to Surgeon General Thomas Parran, the project is designed to provide assistance to state and local health authorities in:

1. Bringing under immediate treatment selectees who have been rejected or deferred by their local selective service boards because of syphilis or gonorrhea and making these men available for military service on completion of treatment.
2. Tracing the sources of infection and rendering potential spreaders of venereal disease noninfectious through prompt and adequate treatment.
3. Placing treatment facilities for gonorrhea on a par with those for syphilis and providing medical and public information on new chemotherapeutic methods for curing gonorrhea.
4. Establishing emergency venereal disease control programs in "boom" towns, where regular public health facilities are insufficient to cope with the problem.

Oglethorpe University Opens New College of Medicine

A new Class A college of medicine, fully accredited under the laws and by the authorities of the state of Georgia, has been announced by Oglethorpe University. While the school is being founded especially for Georgia physicians, applications for admission from all parts of the world will be accepted.

The work of the first two years of the new school will be done on the university campus. The clinical facilities of Grady Hospital, Atlanta, will be made available to third and fourth year students.

Pharmacy Internship Instituted

The Paterson General Hospital, Paterson, N. J., has instituted a pharmacy internship in accordance with the new regulations of the New Jersey State Board of Pharmacy which requires an internship after graduation, part of which can be served in an approved hospital. Alfred Reinhardt, an honor student of the New Jersey College of Pharmacy, is the first person to serve in this hospital in such a capacity.

Bulletin Issued on Protection of Buildings Against Air Raids

Under the title, "Civilian Defense, Protective Construction," a new bulletin has been issued by the Office for Emergency Management, Washington, D. C.

The introduction to the booklet outlines its purpose as follows: "To present the general background necessary for intelligent consideration of the subject of protective construction. In no sense should issuance of this bulletin be construed as the signal to start work immediately on any of the protective structures described. Nevertheless, it is deemed essential that responsible civil officials and civilian engineers give thought to methods, plans and, especially, procedures that can be followed in their respective localities should such protective structures become necessary in the future."

Material for the booklet was gathered from information available from European sources, principally from Britain, and is concerned chiefly with protection of buildings against aerial attacks.

Progressive Expansion Program

An expansion program to be worked out over several years at a cost of between $150,000 and $200,000 is under way at St. Joseph's Hospital, St. Paul.

City of New York Will Build 315 Bed Cancer Hospital Near Columbia

A new cancer hospital, to be known as Florence Nightingale Hospital and to be staffed by Columbia University and erected on land donated by Presbyterian Hospital, will shortly be built by the City of New York, according to a statement in the annual report of the Department of Hospitals published last month by Dr. Willard C. Rappleye, commissioner of hospitals.

The new 315 bed hospital is to be built "in response to the urgent need of replacing the unsatisfactory hospital for cancer with an up-to-date program and, particularly, of securing complete medical services and a research program in this increasingly important group of diseases," Doctor Rappleye states. It is scheduled for completion early in 1943 and will cost $2,650,000.

Other highlights in the annual report cover the development of catastrophe units at Bellevue, Kings County, Morrisania and Queens General hospitals and the extension and coordination of this type of community service to other hospitals, both voluntary and municipal.

The use of sulfonomide drugs has brought a striking reduction in mortality rates in pneumonia, from 29.3% in 1933 to 15.2 in 1940 for lobar pneumonia.

While the city is well supplied with hospitals for the care of acute illnesses, Doctor Rappleye states that one of the most pressing needs is better provision for the care of chronic disease cases.

During 1940 the hospitals in the department had 19,764 beds and an average daily census of 19,303 patients. Excluding new-born infants and the bed capacity of hospitals that were not opened for the whole year, an occupancy of 101.7 per cent is reported. A total of 292,824 patients was treated and nearly three million visits were made to the out-patient departments.

Decline in Gifts and Bequests

A study of philanthropic gifts and bequests in seven large cities in the United States during the first six months of 1941 reveals a slight decline. The compilation shows that such gifts and bequests total $43,051,198 as compared with $45,927,457 during the same period of 1940. A breakdown of the total figure among the various charitable classifications shows $3,508,727 in gifts or bequests granted institutions and organizations concerned with public health for the period of January to June 1941 as against $7,259,045 for this six month period last year.

Public Health Workers Assigned to Active Duty

To assist in coping with public health problems created by the national defense program, 134 new public health workers have been assigned to state and local health departments throughout the nation, the U. S. Public Health Service reports.

The new personnel, consisting of 41 physicians, 39 nurses, 51 sanitary engineers and three laboratory technicians, has completed the one month orientation course at the National Institute of Health, Bethesda, Md., and is now on active duty.

Congress has authorized the continuance of emergency defense and sanitation activities of the Public Health Service and has provided funds for training engineers for malaria control work in southern states. They will begin training at the expanded field station at Norfolk, Va., with headquarters in the Norfolk Marine Hospital.

Tuberculosis Hospital Dedicated

The new $1,000,000 "Silver Crest" Southern Indiana Tuberculosis Hospital which receives patients from 40 southern Indiana counties was formally dedicated at New Albany, Ind., recently.

Civilian Hospital Construction

(*Continued from page* 110)

for the expenditure *from all sources* of $51,188,600 for hospital facilities and $5,005,000 for clinic facilities in these defense areas.

Many of the proposed projects provide for financial participation of the community but in certain cases the federal government is being asked and expects to provide 100 per cent of the cost of construction of needed facilities. It is not anticipated that federal aid will be needed for operation and maintenance of hospitals although other facilities covered by the act will receive allowances for these purposes. Presumably, operation and maintenance costs of the hospitals can be paid by the patients, many of whom will be profitably employed in defense or related activities.

Three hospital projects in Washington, D. C., and vicinity were among the first to be presented to the Federal Works Agency. Garfield Hospital hopes to erect a $4,000,000 new building, providing 650 beds, part of the funds to be supplied as a grant and part as a loan. Columbia Hospital, also in the District of Columbia, has applied for a $700,000 grant to build a new 75 bed addition. Arlington Hospital, in near-by Arlington County, Virginia, plans a new building to cost $1,260,000, part loan and part grant.

A new $650,000 building for Gallinger Municipal Hospital is also contemplated. These four projects are part of a comprehensive program for hospitalization recommended by the Health Security Administration of Washington, D. C.

As might be anticipated from the emphasis on construction for defense purposes only, the hospital construction bill, which was referred to the Senate committee on education and labor in March, has received little attention and is not likely to be enacted during the present session of Congress, although favorable reports have been received by the committee from the Department of Agriculture and the Federal Security Agency.

Children's Facilities Expanded

A $45,000 addition to the children's section of the State University of Iowa Hospitals, Iowa City, has been announced by Robert E. Neff. The new project will constitute enlargement of the orthopedic department and will include massage treatment booths, facilities for hydrotherapy and electrotherapy and gymnasium space, as well as a $3000 therapeutic swimming pool.

Unusual Annual Report Issued

Presbyterian Hospital, Chicago, published last month another unusual annual report, this one being titled "Every Hour of Every Day." The report is profusely illustrated with pictures, drawings and graphs. The opening photograph portrays the hospital in the background of a happy family group with a caption stating that "the modern hospital is always in the background, standing as a sentinel safeguarding life and health against the onslaughts of disease and accident." Facing this is a poem about Presbyterian Hospital by Phyllis A. Goodall. Miss Goodall was secretary to J. Dewey Lutes, administrator of Presbyterian, during the period when he was executive secretary of the A.C.H.A.

Report on Supplies Sent Overseas

Supplies valued at $251,698.08 have been shipped overseas during the past year, leaving an inventory of $27,836.52 on hand, according to the annual report of the Medical and Surgical Relief Committee of America, New York City. Surgical instruments of all kinds still head the list of requests received from all sources, the committee reports. Other supplies for which there is great demand include sulfanilamide and various derivatives, quinine, tryparsamide, antitoxins and vitamins.

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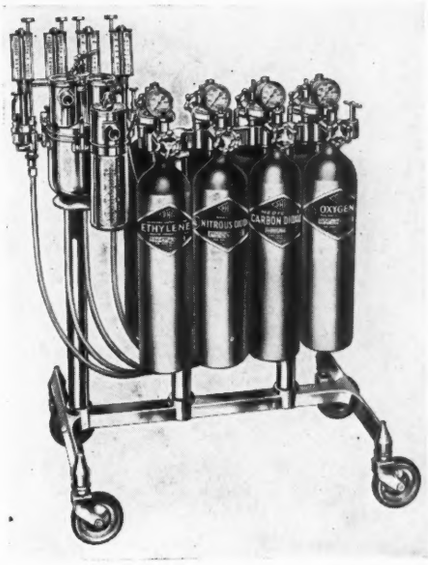

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Names in the News

Administrators

GERHARD HARTMAN, executive secretary of the American College of Hospital Administrators since June 1937, has accepted the position of administrator of the 250 bed Newton Hospital, Newton, Mass., effective January 1. He succeeds BERTHA W. ALLEN, who has been connected with the hospital since 1907 and superintendent since 1915, except for a five year period when she was superintendent of Lowell General Hospital, Lowell, Mass. Miss Allen is planning to retire. Mr. Hartman has also been assistant professor of hospital administration at the University of Chicago and has assisted Dr. Arthur C. Bachmeyer in the conduct of the graduate course in hospital administration at that university. He and Doctor Bachmeyer have collaborated in the preparation of a book, soon to be published, to be entitled "Readings in Hospital Administration."

Corboy

JOHN L. PROCOPE has been appointed administrator of the Flint-Goodridge Hospital, New Orleans, replacing A. W. DENT, who has been made president of Dillard University. Mr. Procope has had eight years in hospital administration, the last two of which have been spent in Mercer Hospital, Philadelphia, as business manager. Previous to that time he was superintendent of the People's Hospital in St. Louis.

N. JOSEPHINE CASS, superintendent of W. B. Plunkett Memorial Hospital, Adams, Mass., for more than twelve years, has announced her resignation, effective September 1. Miss Cass will be succeeded by MARTHA VAN WERT of Keene, N. H.

DR. WILLIAM LELAND HOLT JR., formerly on the staff of Worcester State Hospital, Worcester, Mass., has been named assistant superintendent of Westboro Hospital, Westboro, Mass.

MARK L. BALL, former assistant superintendent of Auburn City Hospital, Auburn, N. Y., has been appointed business manager of Massachusetts Osteopathic Hospital, Boston.

DR. CHARLES A. ZELLER, superintendent of Farview State Hospital, Waymart, Pa., has been named superintendent of Philadelphia State Hospital, Philadelphia, to succeed DR. HERBERT C. WOOLLEY on September 1.

MRS. ALMA IMHOFF SCHIEK, R.N., was elected superintendent of the Greenville Hospital, Greenville, Pa., by the board of directors to replace MRS. MARY A. WIGMORE, who resigned July 1.

ANN S. MORGAN has been appointed assistant administrator of Lawrence and Memorial Associated Hospitals, New London, Conn. Mrs. Morgan has been employed by the hospitals since September 1935.

DR. JAMES A. PRICE has retired as head of Oakville Sanatorium, Oakville, Tenn., and will be succeeded by DR. FELIX A. HUGHES.

ROBERT M. SCHNITZER has been appointed administrative intern at the Memorial Hospital in Orange, N. J. Mr. Schnitzer had been associated with the Mercer Hospital in Trenton, N. J., prior to completing the course in hospital administration at the University of Chicago.

REV. B. O. LYLE has been elected superintendent of Nebraska Methodist Hospital, Omaha.

DR. WILLARD L. QUENNELL has been named director of Union Memorial Hospital to succeed the late DR. CLYDE D. FROST.

Raise dietary standards, lower operating costs with Ideal food conveyors

● Clinical problems of nutrition are readily solved when Ideal Conveyors bring fresh, hot, flavory food to the bedside without trouble or extra effort. Budgetary considerations are valuably served by Ideal time- and labor-saving efficiency.

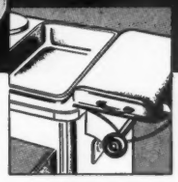
These facts are proved daily in thousands of hospitals where Ideal Food Conveyor service is regarded as a prime essential of good management.

Ideal leadership in the hospital food service field is rooted in years of experience in the engineering and building of food conveyors for hospitals. There are many different Ideal models, each available in different materials, providing an Ideal Conveyor to meet any budget requirement.

Write for detailed specifications.

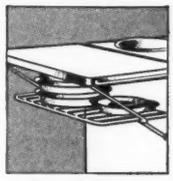
Ideal Conveyors are on display at the American Hospital Association Convention meeting in Atlantic City, Sept. 15-19. Booths 339, 341, 343. We invite your inspection.

Model No. 1431—All Ideal Food Conveyors have Full Underwriters' Approval, in-built safety, smooth, rigid, all-welded body construction, long life, good appearance.



Rounded, Seamless Corners

Complete sanitation, easy cleaning inside and out provided by seamless, rounded corners.



More Shelf Area

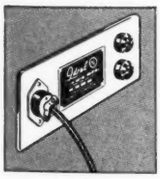
Ample space provided for speedy service and handling of trays. Side serving shelves optional.

Patented Bridge-type Assembly

Top deck cannot sag. Food wells and heating elements held rigidly in place.

Extra Space for Food

Slide-easy warming drawer to hold standard utensil doubles meat tray capacity.



Automatic Temperature Control

Normal moisture and palatability of food maintained at all times.

Scientific Food Distribution

Engineering and wheel placement provide effortless ease in handling unit even in outdoor model shown at left.

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ELYRIA, OHIO

MABEL M. KORSELL will take over her duties as superintendent of Ashton Memorial Hospital, Pipestone, Minn., on September 3.

ANNA GRACE WILLIAMS, R.N., superintendent of the G. N. Wilcox Memorial Hospital, Lihue, Kauai, Hawaii, has resigned. Miss Williams has headed the hospital since its opening in November 1938. She will be succeeded by ESTELLE ANNESSER, R.N., formerly associated with Queen's Hospital, Honolulu.

ETHEL LANE GUILKEY, formerly superintendent of Methodist Hospital, Sioux City, Iowa, sailed on July 26 for Seward, Alaska, to take over her new duties as superintendent of Methodist Hospital.

Miscellaneous

DR. JOHN W. LAWLAH, medical director of Provident Hospital, Chicago, since 1936, has been appointed dean of the medical school of Howard University, Washington, D. C. DR. JOHN B. WEST succeeds Doctor Lawlah as medical director of Provident Hospital. Doctor West also is assistant bureau chief in epidemiology of the Chicago board of health and will devote special attention to problems of Negro health in Chicago. DR. HOMER V. WILBURN has been appointed chief of staff at Provident Hospital.

DR. FRANCIS M. GROGAN, superintendent of City Sanitarium, St. Louis, since 1934, has been named hospital commissioner of St. Louis, replacing DR. RALPH M. THOMPSON, who resigned.

DR. A. H. WOODS has retired as head of the department of psychiatry and director of the psychopathic hospital at the University of Iowa, Iowa City. Doctor Woods' retirement terminates thirteen years of service to the university.

Department Heads

HENRIETTA FROEHLKE will assume her new duties as director of nursing at Presbyterian Hospital, Chicago, in September, succeeding DOROTHY ROGERS, who was married on August 4 to Whiting Williams of Cleveland. Miss Froehlke has been director of nursing at the University of Kansas Hospitals, Kansas City, since 1927.

MRS. DOROTHY JACKSON, supervisor of the obstetrics department of Grant Hospital, Chicago, will become state inspector of nursing schools for Kansas beginning September 1.

DR. WILLIAM A. HAMAN, after fifty years of service on the staff of Homeopathic Hospital, Reading, Pa., will retire on October 16. Of recent years he has been head of the x-ray department.

Deaths

REV. C. B. MOULINIER, S.J., founder of the Catholic Hospital Association and president of the organization from its inception in 1915 until 1928, died at West Baden College, West Baden, Ind., on August 1. Retiring as president of the Catholic Hospital Association in 1928, Father Moulinier was appointed executive director. The following year, when he was withdrawn from the hospital field and assigned other duties, he was named honorary president of the association.

J. E. HALL, one of the incorporators of Hamot Hospital, Erie, Pa., died August 2 following an illness of several years' duration. Mr. Hall founded the American Sterilizer Company after having interested Hamot Hospital in his design for the development of improved sterilization. His interest in civic affairs and charitable organizations was varied and active.

DR. NORMAN CLYDE BAKER, first assistant of Massachusetts General Hospital, Boston, died on July 31. Prior to his association with Massachusetts General Hospital, Doctor Baker was superintendent of the Newport Hospital, Newport, R. I. From 1936 to 1940 he served as secretary of the Massachusetts Hospital Association.

B. H. NOELTING, a substantial contributor to the Deaconess Hospital, Evansville, Ind., and a life member of the hospital association, died in Evans-

ville on June 28. Mr. Noelting was the founder of the Faultless Caster Corporation and contributed a great deal toward the development of that company's line of hospital casters and appliances. He was also active in church and civic affairs. He came to the United States from Germany in 1871 at the age of 20. As soon as the law permitted he applied for naturalization papers and became an American citizen.

Spartanburg Plans Addition

Plans for a $266,000 addition to the Spartanburg General Hospital, Spartanburg, S. C., are under way. The new building will house a 63 room private pavilion; a surgery consisting of five operating rooms and a viewing gallery for teaching purposes; a central heating plant; a laundry building attached to the central heating plant, complete with necessary laundry storage rooms; a large sewing room, and a new kitchen.

U. of California Receives Gift

A gift of $50,000 by the Columbia Foundation has been given the University of California, Berkeley, for the study of applications of the cyclotron to medicine. The gift will enable the university to support for five years a research team of five men trained in as many fields.

Canadian Assembly Discusses National Health Legislation

Intimation that national health legislation may be brought in by the federal government in the near future was the most important news brought forth at the second biennial meeting of the hospitals of the Maritime Provinces held at Pictou, N. S., recently. The associations are awaiting further details before taking definite action, it is reported.

Major topics under discussion at the convention were group hospitalization, public health and preparedness. Public relations was also discussed.

Oliver G. Pratt, superintendent of Salem Hospital, Salem, Mass., represented the American Hospital Association at the meeting.

Conference Program Announced

The tentative program announced by the American College of Surgeons for the twenty-fourth annual hospital standardization conference to be held in Boston, November 3 to 6, includes discussion on preservation of the voluntary system of hospitals, national events and their effect on personnel relations and a preparedness program for hospitals. Panel discussions, round-table conferences and consultation services will round out the three day program.

U. S. Host to Distinguished Scientist

At the invitation of the U. S. Department of State, Dr. José A. Saralegui, distinguished medical scientist of Buenos Aires, is visiting the United States. Doctor Saralegui is a specialist in the field of radiology and is founder of the Argentine Society of Radiology and Electrology. At present, he is a member of the board of the Instituto Cultural Argentino Norteamericano, in which capacity he is interested in the promotion of cultural exchange between this country and Argentina.

Architect for U. of C. Hospital Named

Timothy L. Pfluger of San Francisco has been named architect for the new $2,000,000 teaching hospital for the medical school of the University of California, President Robert Gordon Sproul has announced. Following Mr. Pfluger's appointment, he, F. S. Durie, assistant comptroller of the medical school, and Roscoe Weaver, engineer for the university, began an eastern tour to study recently constructed teaching hospitals.

Clinic Moves Into New Home

The Hurst Eye, Ear and Throat Hospital-Clinic, Longview, Tex., recently moved into a new, completely air-conditioned building. The clinic's bed capacity has been increased from 12 to 25.

"Passed by the Censor"

(*Continued from page* 60)

fares if they desired to see a patient. The following example would illustrate what might happen in London where the greatest difficulties would arise. If a patient who lived six or seven miles southwest of the center of the city happened to go for treatment to a hospital whose in-patient department was 12 or 15 miles north, a visit by relatives would involve a journey of approximately 20 miles each way, probably entailing two or three changes and a tremendous waste of time.

It might be well at this stage to examine briefly the advantages that might be expected from decentralization on the lines indicated. The three most obvious ones which occur to me are:

1. In-patients would be living in the more healthful atmosphere of the country and this should aid their recovery.
2. The hospitals might obtain the release of considerable capital for their work by the sale of the major part of their central sites, which are often situated in parts of the town where land values have been high.
3. The hospital building, in an outlying district where land is cheap, can be planned on a more generous scale than if erected in the midst of a big city; development would tend to be by horizontal rather than by vertical expansion.

Those who are not quite sure of the wisdom of taking the in-patient department to the country are inclined to question whether the advantage to the patient of country air during the average hospital stay of some eighteen to twenty days is really so important and whether the advantages of quiet and the reasonable atmospheric conditions could not be obtained practically as well by the selection of a suitable site at the center, as in the case of the Westminster Hospital. They also doubt, particularly now that various commercial undertakings have learned that it is possible to carry on away from the center of a great city, whether sites that may be for sale would fetch the figure they might have fetched some years ago. They are also not entirely convinced that as good a job cannot be done by vertical development as by horizontal. Much can be said for both points of view.

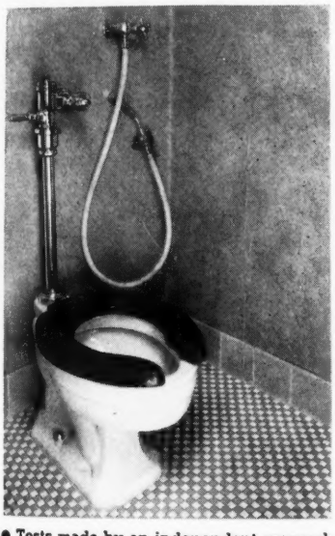
It is too early to prophesy which, if either, of the schools of thought will win an out-and-out victory in the discussion. Some of us are inclined to think that a different solution will have to be adopted in different parts of the country, as one or two of the extralarge centers of population, such as London, present problems of their own. It is possible that in London, for example, there are too many great hospitals with medical schools close in the center of the city and that some of them, like King's, should be moved bodily to serve areas that years ago would have been called suburban. He would be a bold man who would sponsor this suggestion without full investigation not only because of the difficulties involved in breaking up the traditional hospital areas but also because all these hospitals serve patients who come from miles outside the London area.

This month I have only touched on the fringe of one of the post-war problems upon which decisions will have to be taken in the immediate future. At the other extreme, we have the opposite but equally difficult problem of providing adequate hospital services for the thinly scattered populations living in certain parts of Scotland, notably the Highlands and the Islands, but that is another story.

• Fairmont General Hospital, Fairmont, West Virginia. L. D. Schmidt, Architect. Wm M. Clark & Co., New Castle, Pa. Plumbing Contractor

"Everyone comments on how quietly our flush valves operate"

• Miss Marie Robertson, R. N., Superintendent of the Fairmont General Hospital.



• Tests made by an independent research laboratory show that Watrous SILENT-ACTION Flush Valves eliminate an average of 88.5% of flush valve noise energy. These valves—alone among all silent-type flush valves—have no screens, shot or mufflers of any type to become clogged. This assures silent operation that *stays* silent; insures against maintenance problems. Available in diaphragm and piston types.

HERE is what Mr. H. H. Rose, President of the new Fairmont (W. Va.) General Hospital has to say after observing Watrous SILENT-ACTION Flush Valves in use in their new building:

"In our experience in hospital administration we have found that patients are apt to be annoyed by little things that almost escape attention on the part of the staff. When we were building our new hospital, we decided to analyze every possible noise source and eliminate it where practical.

"One of the details we studied was flush valves, and we discovered somewhat to our surprise that ordinary flush valves did make more noise than we had thought and that such noise was transmitted much farther than we had realized.

"We therefore decided to install Watrous Silent-Action Flush Valves and our experience with these valves has been most satisfactory. They are unbelievably quiet—so quiet in fact that a nurse can flush a toilet without awakening a patient in an adjoining room. Everyone here has commented on how quietly our flush valves operate and some of the patients have also mentioned it.

"After our experience here, we don't see how any new building or modernization program could be considered up-to-date unless silent action flush valves were installed."

Fairmont General Hospital,
H. H. Rose, *President.*

The cost of using Watrous SILENT-ACTION equipment in either new or old flush valve installations is extremely small. Before you complete your plans or specifications, we believe you will be interested in getting complete details. Write for our new bulletin, "A Scientific Method of Silencing Flush Valves."

THE IMPERIAL BRASS MFG. CO., 1244 W. Harrison St., Chicago, Ill.

Watrous *SILENT-ACTION* Flush Valves

Books on Review

COMMUNITY ORGANIZATION FOR HEALTH EDUCATION. *A Committee Report. Cambridge, Mass.: The Technology Press,* 1941. *Pp.* 120.

No public health program can realize its maximum objectives without a proper understanding by the public at large of the possibilities that exist for the conservation of health and the prevention of disease. Business and industry have found advertising an essential and recognized vehicle for reaching the potential purchasing public by calling attention in recognized ways to certain values. Preventive medicine has much to offer in the way of life extension and health promotion, and the problem confronting public health workers in the past has been as to the way to present most significantly, in simple and understandable language, a picture of health services of proven value.

The report of the committee and its consultants on community organization for health education presents a picture of contributions made in the field of health education by groups in various parts of the United States, including state, county and municipal health departments and private health agencies. Several sound plans for community organization for health education are described and fundamental principles are stressed.

This book should prove exceedingly interesting to all concerned with methods of presenting health information and interpreting public health values.—CHARLES F. WILINSKY, M.D.

REVIEW OF MANUAL OF SPECIFICATIONS FOR THE PURCHASE OF HOSPITAL SUPPLIES AND EQUIPMENT. *Chicago: American Hospital Association,* 1940.

The Manual of Specifications for the Purchase of Hospital Supplies and Equipment contains valuable reference material for a hospital purchasing agent. It gives detailed specifications for almost every item used in a hospital, from which the purchasing agent can formulate specifications to send to suppliers so that comparable bids can be obtained. The manual is helpful when it comes to the selection of items with which he is not fully familiar. He can refer to specifications in the manual and make a selection of standard articles.

The hospital purchasing agent who desires to purchase to specification will appreciate this manual as one rung in the ladder toward accomplishing his purpose. The manual tells where information regarding tests can be found but many hospitals cannot afford a complete testing laboratory with the necessary equipment and personnel to test thousands of hospital items. Many hospitals cannot afford to delay the receiving of merchandise until sample lots from a shipment have been analyzed by a commercial testing laboratory.

It is true that in hospitals of from 1000 to 1500 beds, where the total cost of merchandise purchased is high in relation to the cost of testing, the plan of laboratory tests before purchase is feasible, but these do not represent average hospitals, the group for which the manual was prepared.

The solution seems to rest with the American Hospital Association, which might well adopt a testing laboratory program, comprehensive enough to answer the hospital purchasing agent's question, "Does a specific article (or articles) meet the American Hospital Association Specification?" When this answer can readily be obtained, the manual will become an invaluable reference book for every hospital purchasing agent.—J. H. WALLACE.

Reader Opinion

Blue Cross Payments

Sirs:

I read your editorial "Blue Cross Payments" in the July issue and congratulate you on the splendid way in which you have handled the subject. I hope that hospitals will never expect Blue Cross plans to "cut melons" merely because it would be financially possible. The important question is not the percentage of subscriber payments that goes to hospitals but rather the adequacy of payments to hospitals for the services rendered.

Adequacy of payment may be compared with the income from nonsubscribers or with the actual costs, if known, of services to these subscribers. Payments on behalf of subscribers in our semiprivate plan are equal to those charged to the general public using such accommodations. A different policy prevails in our ward plan, where we pay the maximum possible percentage of the subscriber income to the member hospitals.

Our ward plan was intended for people of modest incomes. The average rate paid to hospitals for the care of these subscribers is less than the cost of care. Our contract with our member hospitals provides that any surplus left at the end of a fiscal year may, at the discretion of our board of directors, be prorated and divided among member hospitals on a basis of days of hospital service rendered.

The subscriber pays a rate that he can afford; the hospital renders services that exceed average income from such patients, although less than cost. We are not building a reserve fund for these subscribers.

R. F. Cahalane
Executive Director
Associated Hospital Service
Boston

Anniversary Celebration

Sirs:

In 1944 Butler Hospital will observe the one hundredth anniversary of its founding. A committee composed of members of our board has been designated to formulate preliminary plans for the appropriate observance of this occasion. I have been asked to canvass a number of hospitals that have had similar anniversary celebrations in an effort to learn what procedures and methods were followed in similar institutions. It has occurred to me that you of THE MODERN HOSPITAL have had occasion to publish from time to time such events as they have occurred. Perhaps a few outstanding anniversaries come to your mind that were particularly successful.

We are hoping to have an outstanding centennial and should like to benefit from the experiences of others on such occasions and make the one at Butler Hospital as significant and worth while as possible.

Paul J. Spencer
Assistant to the Superintendent
Butler Hospital
Providence, R. I.

One Million Willed to Research

Under the will of George Herbert Jones, trustee of Wesley Hospital, Chicago, and donor of a large share of the funds for the construction of the new Wesley Hospital building, about $1,000,000 has been set aside to promote scientific research to alleviate human suffering, to improve living and working conditions, to improve facilities for recreation, to improve hygiene and prevention of disease and to assist care of children, the sick, aged and helpless.